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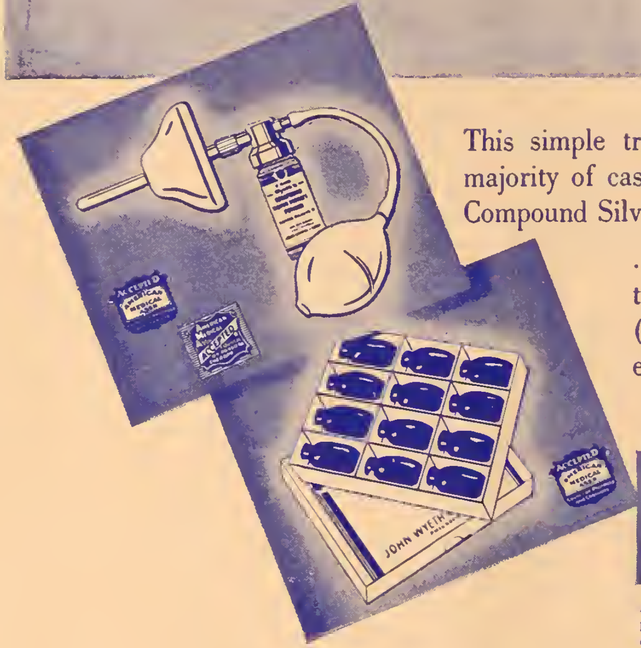

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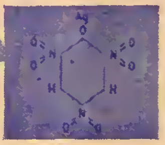

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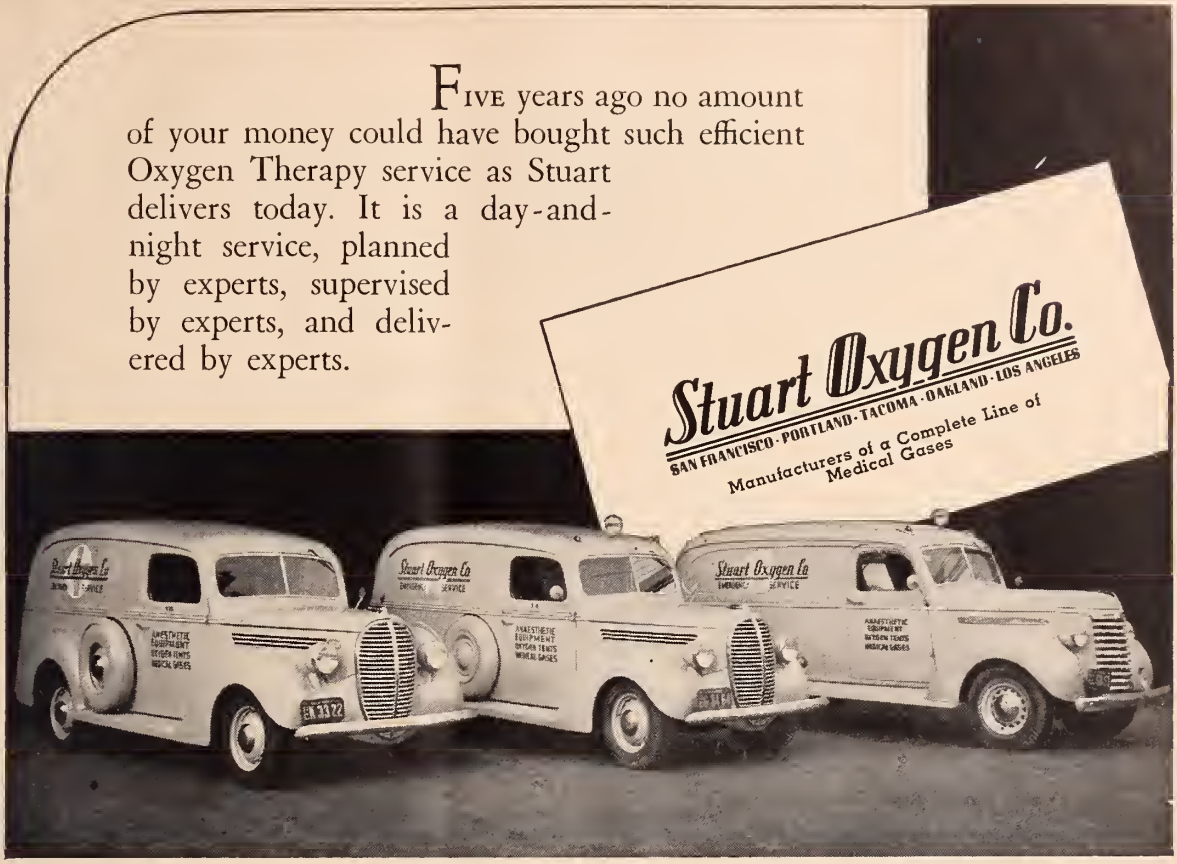
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(Continued on Page 5)

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Alameda County Medical Association
2404 Broadway, Oakland

President, Clifford W. Mack, Livermore Sanitarium, Livermore.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
President, Charles E. Plumb, 310 Main Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Secretary, J. M. Boomer, American Trust Building, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, William G. Milholland, 711 Bank of America Building, Fresno.
Secretary, Jerome A. Thormann, Power Company Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Charles C. Falk, Sr., 507 F Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, T. E. Bartholomew, 319 Third Street, Calexico.
Secretary, Henry Forcher, 319 Third Street, Calexico.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, William I. Shultz, 408 N. Main Street, Bishop.
Secretary, Joseph W. Telford, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. M. Nicholson, Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, G. R. Fortson,* Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles

President, E. Vincent Askey, 2210 W. Third Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles*

Marin County Medical Society
President, Rodney B. Hartman, 38 Bigelow, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, John H. Lloyd, Fort Bragg.
Secretary, Louise E. Petty, Talmage.
Meeting, *On Call.*

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Rollin Reeves, 32 E. San Luis Street, Salinas.
Secretary, S. Condit Glasgow, 8 E. Alisal Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth,* Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, D. A. Harwood,* 2145 Walnut, Santa Ana.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Edward S. Babcock, 1127 Eleventh Street, Sacramento.
Secretary, Carl E. Burkland, 510 Medico-Dental Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.*
Secretary, Arthur E. Virden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
President, W. Don Rolph, 640 National Avenue, National City.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Sidney J. Shipman, 490 Post Street, San Francisco.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Curtis M. Galt, 134 N. Lincoln Avenue, Manteca.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. F. Ragsdale, 717 Twelfth Street, Paso Robles.
Secretary, Harrison Eilers, Box 360, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, William A. Key, 23 Second Avenue, San Mateo.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, J. Irving Beattie,* 652 E. Santa Clara Street, San Jose.
Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
President, F. P. Shenk, Medico-Dental Building, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President*

Shasta County Medical Society
President, Oscar Jess Hansen, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Clifford M. Carlson, 576 B Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, 107 Crescent Road, San Anselmo.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, Frank L. Doane, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, G. C. Coffey, Bank of America Building, Ventura.
Secretary, M. M. Raines, 34 North Ash Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Ray E. Nichols, Woodland.
Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, John W. Lindstrum, 423 Fourth Street, Marysville.
Secretary, Joseph J. Salopek, 423 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

(Roster lists continued on advertising page 6)

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(Continued from Page 3)

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Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento.

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco. Phone WEst 8000.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles. Phone Fitzroy 7694.

Note.—The Library of the American Medical Association, 535 North Dearborn Street, Chicago, Illinois, also maintains a medical literature packet service.

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Anesthesiology

Chairman, Ernest H. Warnock, 1136 West Sixth Street, Los Angeles.
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Los Angeles—906 State Building.

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President, Ray B. McCarty, 3116 Main Street, Riverside.

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The Therapy of the Neuroses and Phychoses. A Socio-Psycho-Biologic Analysis and Resynthesis. By Samuel Henry Kraines, M. D., Associate in Psychiatry, University of Illinois, College of Medicine; Assistant State Alienist, State of Illinois; Diplomate of American Board of Psychiatry and Neurology; Captain, Unitel States Army Medical Corps. Second Edition, thoroughly revised. Cloth. Price $5.50. Pp. 567. Philadelphia: Lea & Febiger, 1943.

Pictorial Handbook of Fracture Treatment. By Edward L. Compere, M. D., F. A. C. S., Associate Professor of Surgery, Northwestern University Medical School; Chairman, Department of Orthopaedic Surgery, Wesley Memorial Hospital; Consulting Orthopaedic Surgeon, Chicago Memorial Hospital; and Sam W. Banks, M. D., Associate in Surgery, Northwestern University Medical School; Attending Orthopaedic Surgeon, Chicago Memorial Hospital. Cloth. Pp. 351, with illustrations. Chicago: The Year Book Publishers, Inc., 1943.

The Cameron Heartometer. By Will J. Cameron. Paper. Pp. 27. Chicago: Cameron Heartometer Company, 1942.

Pain Mechanism: A Physiologic Interpretation of Causalgia and Its Related States. By W. K. Livingston, Lieutenant Commander, M. C., U. S. N. R.; Assistant Clinical Professor of Surgery, University of Oregon Medical School, Portland, Oregon. Cloth. Price $3.75. Pp. 253, with illustrations. New York: The Macmillan Company, 1943.

A Handbook of Medical Library Practice. Including Annotated Bibliographical Guides to the Literature and History of the Medical and Allied Sciences. Based on a Preliminary Manuscript by M. Irene Jones. Compiled by a

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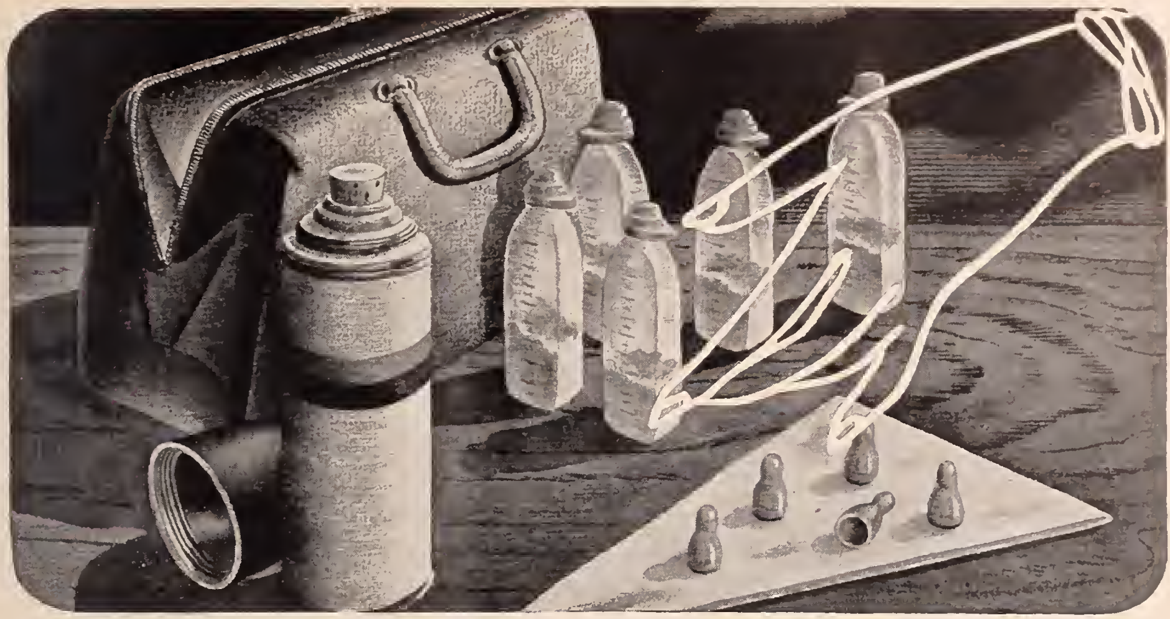

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Committee of the Medical Library Association, Janet Doe, **Editor.** Cloth. Price $5.00. Pp. 609. Chicago: American Library Association, 1943.

Atlas of Obstetric Technic. By Paul Titus, M. D., Obstetrician and Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; Secretary, American Board of Obstetrics and Gynecology. Cloth. Price $7.00. Pp. 180, with illustrations by E. M. Shackelford, Medical Illustrator, John C. Oliver Memorial Research Foundation, St. Margaret Memorial Hospital, Pittsburgh. St. Louis: The C. V. Mosby Company, 1943.

BOOK REVIEWS

Pictorial Handbook of Fracture Treatment. By Edward L. Compere, M. D., F. A. C. S., Associate Professor of Surgery, Northwestern University Medical School; Chairman, Department of Orthopaedic Surgery, Wesley Memorial Hospital; Consulting Orthopaedic Surgeon, Chicago Memorial Hospital; and Sam W. Banks, M. D., Associate in Surgery, Northwestern University Medical School; Attending Orthopaedic Surgeon, Chicago Memorial Hospital. Cloth. Pp. 351, with illustrations. Chicago: The Year Book Publishers, Inc., 1943.

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*Hirsch, M. M., and Novak, M. V.: Evaluation of Germicides with Relation to Tissue Toxicity. Proc. Soc. Exper. Biol. and Med., June, 1942.

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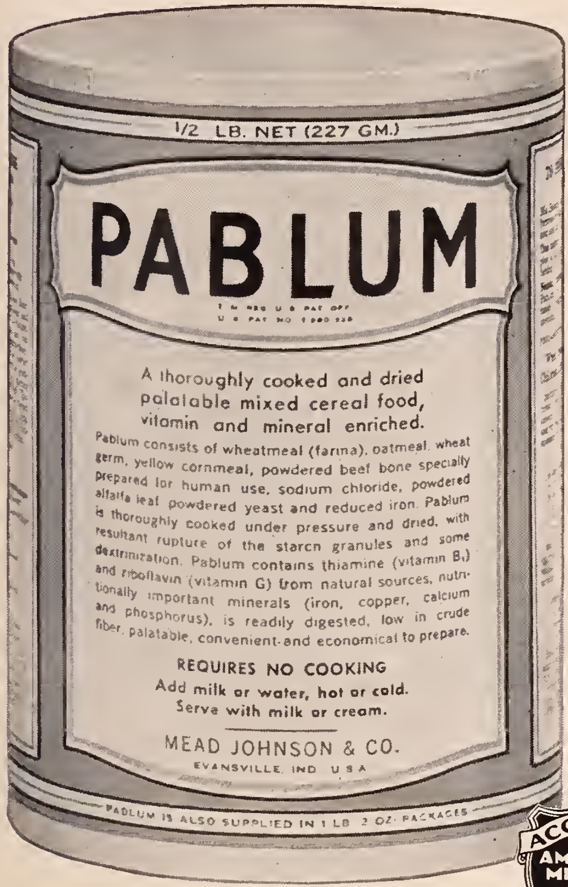
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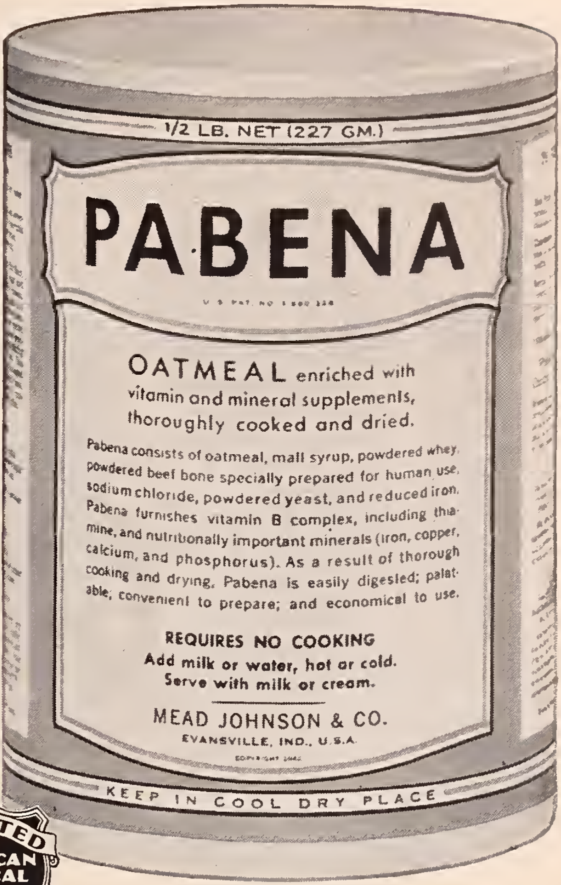
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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241. N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592*

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(Continued from Page 14)

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Vincent's Angina, with Report of a Case," by Joseph M. Kind, M. D., Los Angeles.—In presenting the subject of Vincent's angina to you today I am actuated by a desire to call your attention to what I believe to be a very common affection not commonly recognized, to excite discussion of its management, to call attention to the great diversity of treatments which have been advocated, and to report an unusual case. . . .

From an Article on "Neurological Aspect of Brain Tumors," by W. F. Schaller, M. D., San Francisco.—I wish to present to you briefly my personal experiences in 30 cases of brain tumor seen in the past seven years. This material consists of proven cases of tumor either at operation or autopsy. The diagnosis, when made, has been the result, in most instances,—practically all in fact,—of the work of many different clinicians. For example, both in clinic and private practice, it has been usual, in order to obtain all the possible available data, to get the findings of the ophthalmologist, aurist, roengenologist and serologist, in addition to the usual laboratory work. Only by a proper consideration and evaluation of the data thus obtained is one usually justified in making a definite diagnosis of brain tumor; for it is often by elimination of other possible conditions that a diagnosis of brain tumor is made. . . .

From an Article on "The Cause and Prevention of Post-Operative Gas Pains," by Walter C. Alvarez, M. D., San Francisco.—So-called gas pains constitute one of the surgeon's bugbears. Some of these pains may be due to cramp-like spasms or to incoördinated, conflicting waves running over an irritable bowel; others, however, are certainly associated with the accumulation of gas. If an ounce of prevention is worth a pound of cure, it goes without saying that the surgeon, in preparing his patients for operation, should make every effort to preserve and safeguard the mechanism which normally keeps us free from gas and pain. It is my object in this paper (1) briefly to review what knowledge we have of the physiologic processes underlying this mechanism; (2) to point out in what way the results of research differ from the commonly accepted ideas; (3) to make a plea against the routine tinkering with this machinery before operations which are often to decide the issue of life and death, and (4) to review briefly the measures which can be employed before and after the pains appear. . . .

Excerpts from Minutes of the House of Delegates—Forty-Seventh Annual Session of the Medical Society of the State of California.—FIRST SESSION. Held at Hotel Del Monte, Tuesday evening, April 16, 1918, 8:30 o'clock. . . .

Excerpts from Report of the Council.—The President then called upon the Chairman, C. G. Kenyon, who read the following report of the Council:

Mr. President, and the Honorable House of Delegates:
Gentlemen:

I beg to report the Council has passed the century milepost; the last being the 102nd meeting since its organization, and the beginning of its work. . . .

Publicity Bureau. Another feature of the work laid out for the Council was the organization of the Publicity Bureau. This has assumed a definite shape, and is at present in working order within the Society. The members should recollect that this department of the Society was established

(Continued on Page 17)

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

to take up several definite lines of work. These are mainly to promote organization, to represent the Society in the eyes of the public, and to deal with matters of policy and legislation. . . .

National Defense. The State Organization for National Defense has been active in a quiet way throughout the year. Its membership comprises nearly twenty (20) of our most representative men and women. The Committee has kept in intimate touch with Washington through all phases of the war; assisted in organization and development of working units. It has helped in the appointment of the members on the Medical Advisory Boards, and in furthering propaganda and dictating national legislation. . . .

Excerpt from Report of the Secretary.—The President then called upon the Secretary, Saxton Pope, who made the following report:

The Secretary reported that, notwithstanding the loss of membership throughout the State, from military enrollments [during the fiscal year 1917-1918], our roster of names was over 2300. During the year more than 600 of our men had joined the colors, which gives a high percentage of our best physicians in service. In spite of this loss, the Society was progressing and saving money. . . .

Excerpt from Report of Committee on Industrial Accident Insurance.—Your Committee, after another year's consideration, begs to report as follows:

The three subjects which this Committee was asked to consider were the possible increase in fee schedule, the free

(Continued on Page 18)

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TWENTY-FIVE YEARS AGO

(Continued from Page 17)

choice of physicians by the injured, and the medical ethics involved in Industrial Accident Work.

Your Committee believes that the present minimum fee schedule, as usually interpreted, is not satisfactory to skilled surgeons, the class of men desired by the Commission, especially as usually interpreted by the Medical Director of the Fund and the adjusters of the Insurance Companies.

We wish again to call your attention to the fact that members have two resources for adjustment of bills which are in controversy, with the Insurance Companies: first, with the Adjustment Committee of the California State Medical Society, and, second, through the Medical Director of the State Fund; the Commission being the final court of appeal in all such matters. . . .

Excerpt from Report of the Committee on Health Insurance:—

Mr. President and Fellow Members:

Your Committee's first report was published in full in the June, 1917, issue of the California State Journal of Medicine. In this report we summarized the arguments for and against the health insurance bills that have been proposed in this country. We felt that the State Society should, as a whole and not simply through a small committee, familiarize itself with this big, broad subject of Social Insurance, and that its members should not, ostrich-like, bury their heads in the sand, refusing to see the issue and meet it squarely.

Your Committee on New Business then recommended, and you adopted, the following:

(a) That the House of Delegates concur in the conclusions of the Special Committee, that the legal institution of the proposed plan of compulsory health insurance by the State of California does not seem to be advisable at this time, and that our Council be instructed to at once take steps to see to it that our viewpoint in this matter be made as politically effective as possible.

(b) That the present Special Committee on Social Health Insurance be continued, and be requested to further study this problem, and to make a report thereon at our next annual meeting.

(c) That the House of Delegates adopt, in addition, the resolution introduced, to wit: . . .

Since these resolutions were adopted, the amendment to the Constitution, proposed by the Social Insurance Commission, has received the endorsement of both houses in the Legislature, and will be submitted to the citizens of the State in November, 1918. . . .

Senator Johnson went on record in favor of social health insurance in his farewell address to the Legislature of January 8, 1917. Governor Stephens went on record in favor of social health insurance, as well as other forms of social insurance, in his speech of March 23, 1917. . . .

Mr. Chester Rowell, editor of the Fresno Republican, a man widely and well known throughout the State, is Chairman of the Social Insurance Commission of the State of California. He is one of the strongest advocates of health insurance, and upon his return from the South Sea Islands will do all he can to foster the movement. . . .

Your Committee feels that, if the citizens of this State endorse the amendment, they will also look to us to guarantee them proper medical care. In return, they will assure us their support in our attempt to properly organize, standardize and finance the medical profession, so as to give the public the best possible service, and this without in any way asking us to lower our standards of education, ethics, or of living. . . .

(Continued on Page 20)

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

We have therefore outlined, as follows, the medical provisions which we believe this Society should endorse. We stand for them, each and every one of them, and believe you should adopt them all and be ready to fight for them. Anything less would be failure on our part to protect the public which looks to us for guidance in these matters. . . .

(Signed) RENÊ BINE,
Chairman, Committee on Social Insurance.

Excerpt from New Business — Address of Barbara Nachtrieb Grimes.—Dr. René Bine moved that the privilege of the floor be granted to Barbara Nachtrieb Grimes, which was duly seconded and carried. Mrs. Grimes then took the floor and addressed the House on the subject of Social Health Insurance.

The meeting was adjourned to meet Wednesday evening, April 17, at 8:30 o'clock.

Excerpt from Second Session, Wednesday evening, April 17, 1918, at 8:30 o'clock.—The President then made the announcement that the place of meeting for 1919 would be Hotel Potter, Santa Barbara, California.

ELECTION OF OFFICERS

Nominations for President were declared in order.

President—Dr. C. Van Zwalenburg of Riverside was nominated for President by Dr. Andrew S. Lobingier of Los Angeles, said nomination being duly seconded. On motion, duly seconded, the Secretary was instructed to cast the ballot of the House for Dr. C. Van Zwalenburg for President. The Secretary duly cast the ballot, and Dr. C. Van Zwalenburg was declared elected President of the Society for the ensuing year. . . .

Excerpt from Report of the Committee on New Business.—Your Committee on New Business begs leave to report the following for the consideration of the House of Delegates: . . .

Constitution and By-Laws. Amendments to the Constitution and By-Laws were presented by Dr. Jas. H. Parkinson on behalf of the Council.

Dr. Geo. H. Evans made a motion that these amendments be laid on the table until next year. No second to this motion.

The following amendments to the Constitution were then presented for action at the next annual meeting:

CONSTITUTION OF THE MEDICAL SOCIETY
OF THE STATE OF CALIFORNIA
ARTICLE I.

Name and Object.

Section 1. The name of this Society shall be the "Medical Society of the State of California."

Sec. 2. The purpose of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of California, and to unite with similar societies of other States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians, to guard and foster the material interests of its members and to protect them against imposition; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life. . . .

(Continued on Page 22)

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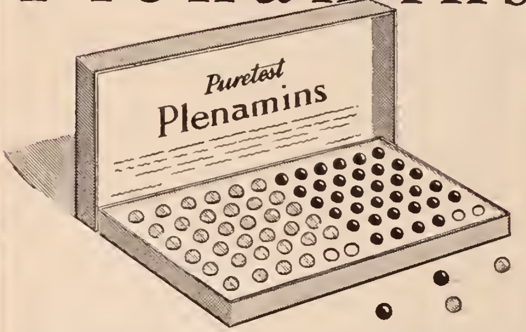

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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

Excerpts from Correspondence—World War I—From Dr. R. H. Hunt.—

U. S. S. "Corsair," May 12, 1918.

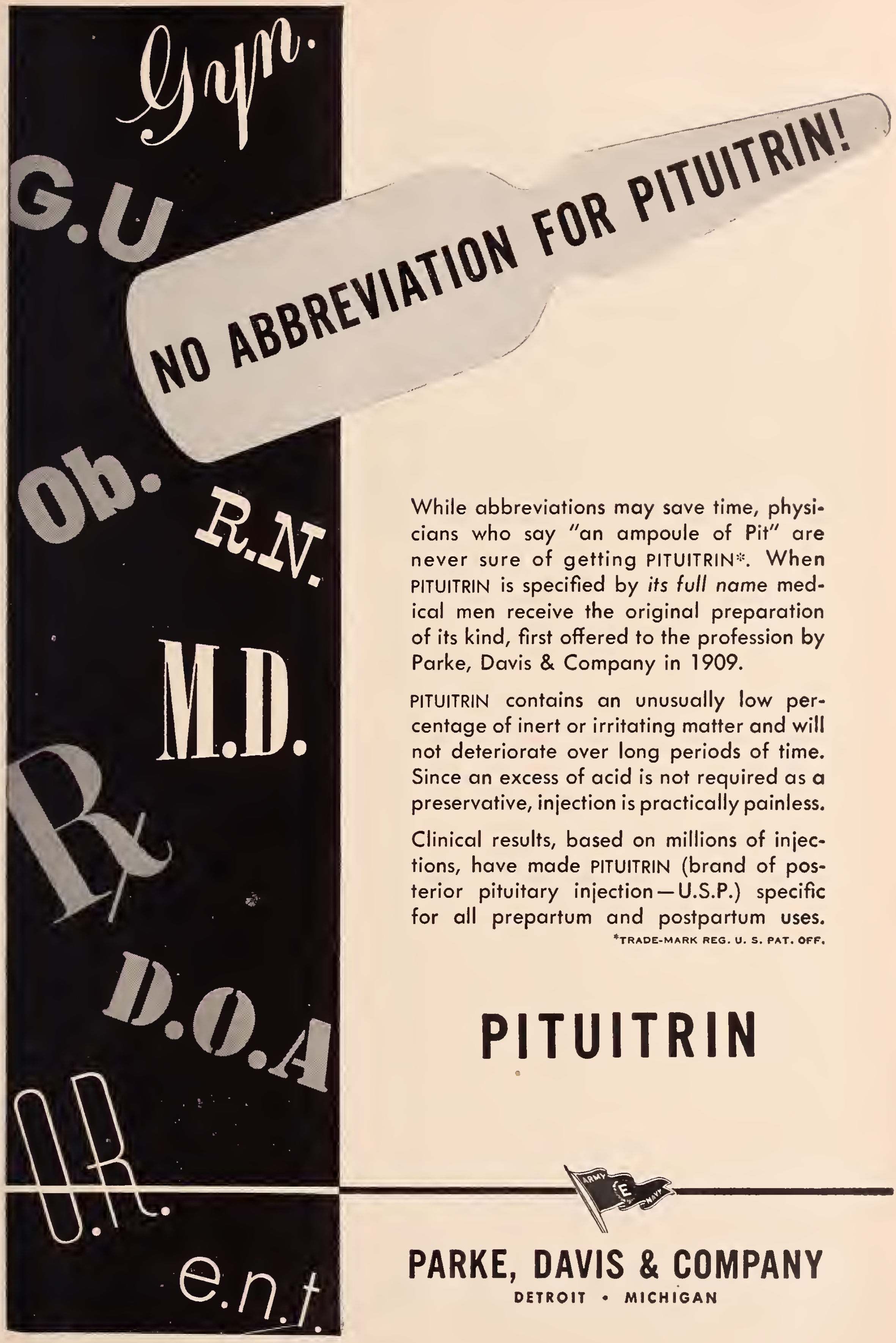
My Dear Doctor Beckman:

Well, as per agreement, I will drop you a line to let you know that I have changed my address, not a great change but enough to make note of. . . .

The "Corsair" belonged to Mr. J. P. Morgan and I am very much obliged to him for having such a comfortable, large and fast ship, and besides, one that looks very good. Mr. Censor, a very, very nice fellow, does not want me to tell you the kind of work that we are doing, so I will not cross him by saying other than that we have work to do which has its joys, thrills, dangers and leisure. . . .

The work is booming here and every time we come in we can see the changes that have taken place since we left. The American forces are putting in a lot of work over here. It seems that we cannot learn to use the facilities that they have over here, though the French have made them do for a long time. The first thing that everyone does when they see a freight train and engine is to say: "Toot, toot," for they do look so much like a toy. The French are showing some difficulty in understanding our methods and I fear they do not fully appreciate what we have done already. much of it seems so useless to them. I think, though, that in a very short time we shall be having them look at us in the right light. The peasants who are in the towns seem to take the American soldier as a sort of a tourist,

(Continued in Back Advertising Section, Page 28)



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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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EDITOR . . . . GEORGE H. KRESS

Committee on Publications

F. Burton Jones..........Vallejo 1944
Francis E. Toomey..........San Diego 1945
George W. Walker (Chairman)..........Fresno 1946
Secretary and Editor ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . . JOHN HUNTON

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Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

DEPARTMENT INDEX

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EDITORIALS

FEDERAL CHILDREN'S BUREAU PLAN OF MATERNITY AND INFANT CARE FOR WIVES AND INFANTS OF MEN IN THE ARMED FORCES

California Medical Association Members Should Appreciate the Important Issues Involved.—War time is not a period favorable to expression of opinion that may be in opposition to pronouncements by governmental bureaus, since the publicity departments or spokesmen of agencies involved can always raise the cry, "Nothing must be done to impede all-out effort to win the war."

With that slogan all are in agreement, but it does not follow that those who use it are necessarily in the right when they resort to it in order to defend methods of action for which they are the special proponents. Particularly so when, if the objectives be acceptable, the slogan is used to discourage legitimate criticism of certain governmental methods of procedure.

The above statement is made because the position taken by the California Medical Association, in refusing to approve a schedule of fees for professional services to be rendered to pregnant wives of enlisted men, is quite apt to be misunderstood and misinterpreted, although the Association is in full accord with the desired objectives.

It is important that members of the California Medical Association promptly familiarize themselves with the facts relating to professional care of wives of enlisted men. Every member who may be consulted or called on to do obstetric or pediatric work for the group of prospective patients mentioned should take the time to at least scan the information contained in the comments which appeared in the June issue of CALIFORNIA AND WESTERN MEDICINE, on pages 314-317, at which time the Children's Bureau plan was brought to the official attention of the medical profession in California.

After the comments in the June number of CALIFORNIA AND WESTERN MEDICINE have been read, understanding consideration may then be given to the official and other actions that have been taken since the editorial was written.

* * *

Additional Information in Current Issue.—The story of subsequent official communications and correspondence appears in this issue under the department of the "Committee on Participation of the Medical Profession in the War Effort." (See page 79.)

As has been stated previously, the issues involved are of paramount importance to present and future medical practice and standards.

The California Medical Association through its constituted authorities, has deemed it to be to the best interests of all concerned not to accept a mandatory fee bill for certain professional services as emanating or promulgated from the Children's Bureau in Washington, D. C.

To make its point of view a matter of record, and for the further information of members of the California Medical Association, the correspondence referred to below is given space in this issue.

The eighteen items referred to are listed as follows:

Item I.—Letter of May 24, 1943: (Letter to Los Angeles Subcommittee Concerning California Fee Schedules.)

Item II.—Letter of June 1, 1943: (Letter to A. M. A. Secretary West Regarding Obstetric Fee Schedules.)

Item III.—Letter of June 3, 1943: (Letter from A. M. A. Secretary West Regarding Their Files on Obstetric Fee Schedules.)

Item IV.—Letter of June 23, 1943: (Letter from Public Health Director Halverson Concerning Proposed Obstetric Plan.)

Item V.—Letter of June 25, 1943: (Letter from Council Chairman Gilman Requesting Information from State Board.)

Item VI.—Resolution of June 20, 1943: (Resolution of C. M. A. Council, adopted at its meeting in San Francisco on June 20, 1943.)

Item VII.—Resolution of June 8, 1943: (Resolution of A. M. A. House of Delegates, adopted in Chicago on June 8, 1943.)

Item VIII.—Resolution of May 30, 1943: (Resolution of Pacific States Medical Executives' Conference, adopted at its meeting in Portland, Oregon, on May 30, 1943.)

Item IX.—Letter of June 30, 1943: (Letter from Dr. Daily of Federal Children's Bureau to State Health Director Halverson.)

Item X.—Letter of July 1, 1943: (Letter of Council Chairman Gilman to State Health Director Halverson Concerning Point of View Held by California Medical Association.)

Item XI.—Letter of July 1, 1943: (Letter to Members of Component County Medical Societies Concerning Procedure Available for C. M. A. Members in Relation to Obstetric Work.)

Item XII.—Letter of June 29, 1943: (Letter from A. M. A. Secretary West Concerning Obstetric Files.)

Item XIII.—Letter of July 8, 1943: (Letter to Dr. Daily of Federal Children's Bureau from C. M. A. Secretary Requesting Information Concerning Fee Schedules.)

Item XIV.—Letter of July 6, 1943: (Letter from Indiana State Medical Association Requesting Copies of C. M. A. Council Letters to County Medical Societies.)

Item XV.—Letter of June 17, 1943: Letter from Michigan State Medical Society containing memoranda for members of the Michigan State Medical Society.

Item XVI.—List of California Senators and Congressmen, with addresses. (Note: County societies and California Medical Association members may wish to write to their Senators and local Congressmen. See suggestion at end of letter of Ohio State Medical Association, as appearing under Item XVIII.)

Item XVII.—Table showing births in California: (a) all births; (b) births, wives of enlisted men.

Item XVIII.—Letter of July 17, 1943: (Informative comment and letter to members of the Ohio State Medical Association.)

Items Should Be Scanned and Letter to County Societies Should Be Read.—It is to be hoped that members of the Association will take the time to at least scan the above items, and also to read in full the letter addressed to the component county medical societies, in which the attitude of the California Medical Association is outlined by the Council, and the lines of action for California Medical Association members are indicated.

Letters received from the Indiana, Michigan, and Ohio State Medical Associations reveal the interest which other constituent state medical associations have in the principles at stake. (See Items XIV, XV, and XVIII.) It will be interesting to watch the course of future events in the Children's Bureau plan.

In the meantime, county medical societies of California, and California Medical Association members also, may wish to write to the Senators and to their district Congressmen (list of California Senators and Congressmen appears under Item XVI.) The letter of the Ohio State Medical Association contains excellent suggestions (see Item XVIII). The issues involved indicate the importance of prompt action.

NEW PROCUREMENT PROCEDURE TO APPLY TO PHYSICIANS UNDER AGE OF FORTY-FIVE

Important Directive of June 7, 1943, from Directing Board of Procurement and Assignment Service of Office of Emergency Management of War Manpower Commission.—A directive addressed to the State chairman for physicians in States with unfilled quotas of medical officers appears in full in this issue of CALIFORNIA AND WESTERN MEDICINE. (See page 78.) California stands third in such a list of nineteen states, having an unfilled quota as of May 15, 1943; the request being made that an additional 535 California physicians be made available for induction into the armed forces in the year 1943.

In its beginning paragraphs, the directive states:

> . . . Recruitment methods which have been used in the past have not produced the number of physicians who can be spared from the civilian population for service as medical officers nor have they produced the number urgently needed by the armed forces.
>
> In view of these facts, a new recruitment procedure has been agreed upon by the Procurement and Assignment Service and the Army and Navy which will supplement the methods now being used by this service. . . .

Then follow instructions to Procurement officers:

> To list by name and address all physicians under forty-five years of age . . . *who are available, or who can be declared available.*

Later, this statement appears:

> At regular intervals the Army and the Navy will return to you the names of men who have not accepted commissions. You will submit these names to the State Director of Selective Service, asking that consideration be

given to draft reclassification. A copy of your letter to the State Director of Selective Service, together with the names of men whose reclassification you have requested, should be sent to the Central Office so that the information may be transmitted to National Headquarters, Selective Service System.

The implication in the above paragraph is this, that the Selective Service System will reclassify physicians who have been declared available but who have not accepted commissions!

* * *

New Directive Is Receiving Earnest Consideration.—The committees of the California Medical Association and its county societies which have duties related to procurement and assignment service are giving the War Manpower Commission requests their careful consideration, and will do all within their power to have California transferred from the list of States with unfilled quotas to the roster of Commonwealths that are credited with completed records.

* * *

Council's Recommendation Concerning Special Advisory Committees of Senior Physicians.—In connection with the above, the attention of county societies that have not yet filled their quotas is called to the recommendation made by the Council of the California Medical Association on June 20, in which it is suggested that such county societies appoint special committees composed of senior physicians to coöperate with their respective Committees on Participation of the Medical Profession in the War Effort. (This latter committee, in most cases, is one and the same as the County Committee on Procurement and Assignment.)

Recommendation follows:

> The Council voted to recommend to component county societies which have not filled their respective quotas the advisability of appointing committees of senior physicians to coöperate with their local Committees on War Participation in the manner outlined in the resolution considered by the California Medical Association House of Delegates. (In June CALIFORNIA AND WESTERN MEDICINE, see Reference No. 11 on page 350.)

RELOCATION OF PHYSICIANS IN AREAS OF MEDICAL NEED

A Problem in Civilian Practice.—Editorial comment is made in this issue on "New Procurement Procedure to Apply to Physicians Under Age of Forty-Five," and attention is called to a directive having dated June 7 relating thereto.

Of almost equal interest and import is another directive, dated June 5, 1943, from the Office of Emergency Management of the War Manpower Commission, which applies to those other States that have already filled their quotas for the armed forces and that are now being called on to request available physicians within their limits to relocate in areas where the civilian population is suffering from lack of physicians.

The directive dealing with this subject also comes from the Directing Board of the Procurement and Assignment Service, and is addressed to the State Chairmen on Procurement and Assignment. (In California, to Dr. Harold A. Fletcher of San Francisco, and Dr. Edward M. Pallette of Los Angeles.)

Its significance lies in this, that it shows that the Government intends to take active steps to provide medical care for citizens in areas that have population figures far in excess of those set as being a standard for *minimum medical care.*

The pertinent paragraph in the directive follows:

> In your State there are localities where physicians are needed. Will you communicate with the physicians whom you have declared to be available and request them to relocate in areas of medical need. If after two weeks these physicians do not comply with your request, you should send a list of their names and addresses to the Central Office. The Central Office will prepare letters asking them to apply for commissions.

* * *

Significant Excerpts From a Brochure on Doctor Shortage Issued by the U. S. Office of War Information.—Before dismissing the subject of civilian needs for medical care, reference may be made to a 46-page brochure received on June 5 from the Office of War Information, and having the title "The Doctor Shortage and Medical Care of Civilians in Wartime: OWI Report No. 2." The following excerpts may be of interest, especially in relation to this later directive of June 5:

> . . . "Between 40,000 and 45,000 doctors have entered the armed services. As the size of the Army and Navy increases, more will be called. The men in the uniform of the United States have been and will continue to be the best cared for medically in the world.
>
> "But in total war the health and working power of the civilian is as important as the health and striking power of the fighter." . . .
>
> . . . "3. In too many cases physicians were recruited for the armed services without sufficient regard for the welfare of the civilian population. There are, however, enough doctors remaining in private practice to give adequate care to the civilian population, provided they can be properly distributed numerically and according to special abilities.
>
> "4. The voluntary relocation of physicians from communities where there is an abundance of doctors to areas in acute need of doctors has proved extremely difficult and has not resulted in a solution of the problem." . . .
>
> . . . "6. The situation as a whole is not now out of control, but unless remedial steps are taken soon it will grow progressively worse. More physicians will be recruited for the armed forces, and doctors in critical areas, many of them elderly, may succumb to exhaustion from overwork." . . .
>
> . . . "Because of our Federal system and the individual laws of the separate states, the problems of relocation in this country are somewhat more involved than in Great Britain. Normally a physician from one state cannot practice in another without passing that state's medical tests." . . .
>
> . . . "The personal element is also important in attempting relocations." . . .
>
> . . . "One fact which should be realized is that 'luxury' medicine is out for the duration." . . .
>
> . . . "The problem of medical care in rural regions is quite different from the problem in cities, or in large industrial areas." . . .

. . . "As of September 30, 1942, there were considered to be 135,932 effective physicians in the United States. The total number of physicians was 179,039, but some of these are of advanced age, are suffering from physical disabilities, or for other reasons are not practicing. There were on active duty with the Army, 31,400; with the Navy, 6,104; and in the U. S. Public Health Service, 1,069—a total of 38,573. Since September 30, 1942, the date of this estimate, additional doctors have been enlisted. Procurement and Assignment has estimated that if the ratio of one physician to each 1,500 persons in the country is preserved—and this ratio is simply a measuring stick, susceptible to variations—the maximum number of physicians who can be withdrawn from civil practice during 1943 is 11,455." . . .

. . . "Prepaid insurance for doctors' care is being utilized by thousands of war workers, particularly on the West Coast, where there are areas as critically in need of doctors as anywhere in the United States.* Before the war began, medical societies of two West Coast states were supporting group plans for industrial workers, group plans which have proved increasingly beneficial as population figures grew. Doctors throughout these states who coöperate in the plans are assigned to care for groups of individuals and are paid by funds from the Association.

"The group plan in one of these states is proving especially capable of adapting itself to the rapidly changing needs of the population. Before the war, medical insurance was provided for industrial workers and farmers. Now this has been extended to take care of residents of emergency housing projects. It was found that many housing units had been located in regions where the available doctors were already taxed to the limits of their endurance, where the distance from the project to doctors' offices was too great, and where most residents were migrants unable to work out their medical-care problems in new surroundings without help.

"For such 'mushroom' communities the state-wide physicians' service and the Federal Public Housing Authority have coöperated in a plan which brings onto the grounds of the housing project itself a resident doctor, who is paid on straight salary basis, and a nursing staff. For special care beyond the resident doctor's attention, patients are referred to a panel of local physicians who coöperate in the State service program." . . .

. . . "Thus the medical profession itself has adapted a group-care plan to an important war emergency. So far, it operates in four large and congested areas of this state, where not quite 90 per cent enrollment of housing project residents has been reached. War workers elsewhere in the State may soon be given doctors' help under this plan." . . .

. . . "The general conclusion drawn from this investigation is that, while there is not at present a serious breakdown in the health of the nation due to the doctor shortage, there is a probability of slow deterioration of health in communities suffering from medical shortages." . . .

. . . "It is also evident that we can no longer afford to look tolerantly on the scarcity of medical care in rural areas. Farmers have become as important as the man on the fighting front or the man in a shell factory.

"Prenatal and postnatal care for mothers has assumed added importance. As is usual in war time, our birth rate is soaring." . . .

. . . "It is recognized that relocation of doctors is not the whole answer to the problem of medical care for the civilian population in war time. Nurses, hospitals, clinics, nutrition, sanitation, preventive medicine—all play vital parts.

"To these subjects the Office of War Information may return in a later report."

CALIFORNIA'S NONPROFIT MEDICAL SERVICE AND HOSPITALIZATION ORGANIZATIONS

On Types of Medical Service Coverage.—Most California Medical Association members have a personal interest in the medical service organization—California Physicians' Service—since it was sponsored and brought into being by the California Medical Association; and likewise because they, in their relationship as "professional members" of this nonprofit corporation, have been for some four years its major financial backers or underwriters.

The development of California Physicians' Service has not taken place along paths laid with roses. Rather, the reverse. Nevertheless, it is to the credit of this organization that some of its difficulties have arisen, in good part, from an overplus of initial altruism in the expression of which the House of Delegates of the California Medical Association took a leading part.

Without actuarial background to support it, but in a laudable attempt to do much for little—experience has demonstrated, for "far too little"—California Physicians' Service started its career with "full coverage" contracts. That experiment early led it into financial troubles. For, while "full coverage" may be idealistically the procedure to bring into being, in practice that type of contract leads to financial disaster, since the mass-spread or sale of a sufficiently large number of such contracts does not take place; thus permitting a group of less desirable physical risks to call for an extra large amount of professional services. As a consequence the unit value, which itself was placed on a modest basis to compensate physicians for professional services rendered, has been far from realized; and, as a consequence, at the end of four years the rôle of "underwriters" has had less appeal to many professional members.

Subsequently the two-visit deductible contracts were proposed. California Physicians' Service has had about six months' experience with them, and they have had a very definite effect on raising the unit value. Other plans, notably the Michigan Medical Service, have had extensive experience with the limited surgical contract. This is regarded by most medical service plans as being the soundest from an actuarial point of view. The experience of Michigan has shown that even with this limited service it will take approximately three years for the program to balance itself out.

The people of California have been exposed to full coverage, and it is very difficult in certain areas of the State to get popular acceptance of the limited surgical program. This is one of the reasons why California Physicians' Service has offered the two-visit deductible, which is a safe approach to the full coverage plan. Only time and experience and the analysis of carefully acquired statistical data will settle these issues. Two things must be taken into consideration: the needs in relation to the public, and the types and quantity of service in relation to the contracts that might be developed to meet this need.

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* Editor's Note: The second, third and fourth paragraphs may be indirect references to California Physician's Service.

California Medical Association Council's Consideration of California Physicians' Service Problems and Mannix Survey Report.—In this issue of California and Western Medicine appear the minutes of the 311th meeting of the Council of the California Medical Association, held on June 19-20, 1943. Under Item 9 (*California Physicians' Service*) and Item 10 (*Survey of California Medical Service and Hospitalization Organizations—Report of Mr. John R. Mannix, Detroit*) appear the minutes of the Council's consideration of these important subjects. In later issues, these matters will be referred to again. Meanwhile, it is reassuring to learn that plans are in the making to bring about more harmonious relationships between all parties concerned.

The Council of the California Medical Association will hold its next meeting on August 22. Component county societies and members are requested to feel free to send in their suggestions, either direct to the Council or through district councilors or councilors-at-large. All of us are seeking the paths along which medical and hospitalization services in California may be made available to the largest possible number of citizens for whom those services are particularly designed. With broad-minded and wholehearted coöperation by all concerned, that basic objective may be realized.

MEETING OF THE A. M. A. HOUSE OF DELEGATES IN CHICAGO, JUNE 7–9, 1943: REGARDING SOME CALIFORNIA RESOLUTIONS

California as a Medico-Political Guinea Pig. Some years ago certain medical practice problems in California took on political hues, making it necessary for the organized medical profession of the State to become interested in proposals which, had they been carried out, would have seriously impeded the progress of scientific medicine. At that time, physicians in other States of the Union were not confronted with similar attacks. As a consequence, in more than one section of the United States, there were those in the medical profession who raised their eyes in somewhat hopeless despair when the activities of the California Medical Association were under discussion. Not so, however, when later on these same matters came to the front in their own Commonwealths.

These thoughts of happenings in former years flit into the mind, as one's eyes glance over the pages of the July 19, 1943, issue of *The Journal of the American Medical Association* and note the references to resolutions introduced in former years by California physicians in the American Medical Association House of Delegates, and which in this present year have been receiving increasing attention by the Board of Trustees of the American Medical Association.

Without going into details, but with somewhat pardonable pride in the vision of California Medical Association councilors in having California delegates propose for national consideration problems worthy of more than state-wide scope—in the hope of possible solution—there are here mentioned some of the items referred to in *The Journal of the American Medical Association* of June 19, 1943:

(*a*) From page 524, under "Supplementary Report."

SUPPLEMENTARY REPORT OF THE BOARD OF TRUSTEES DEALING WITH HOSPITAL CORPORATIONS ENGAGING IN THE PRACTICE OF MEDICINE

The subject matter covered in this report is contained in three resolutions submitted to the House of Delegates as follows. . . .

2. The resolutions introduced by Dr. Harry H. Wilson, California, at the Cleveland session in 1941.

3. The resolutions introduced by Dr. Lyell C. Kinney, California, at the Atlantic City session in 1942.

* * *

(*b*) This item from *The Journal of the American Medical Association* of June 19, 1943, on page 526.

SUPPLEMENTARY REPORT OF BOARD OF TRUSTEES DEALING WITH REPORT OF PROCEEDINGS OF THE JOINT COMMITTEE MEETING OF NATIONAL HOSPITAL ASSOCIATIONS AND REPRESENTATIVES OF THE BOARD OF TRUSTEES OF THE AMERICAN MEDICAL ASSOCIATION

Factual Data From Conferences

From page 527:

The resolutions of the House of Delegates of June, 1942, were read as follows:

> Whereas, The House of Delegates approved a resolution introduced by Dr. Harry H. Wilson at the 1941 session instructing the "Board of Trustees of the American Medical Association . . . to confer with similar committees representing the American Hospital Association and the Catholic Hospital Association of the United States, the conjoint committees to study and submit reports to their respective national bodies, in which would be outlined platforms or principles designed to clarify the relation of medical services that may be offered in prepayment hospitalization and similar plans, the same to be in line with the basic principles laid down in the past by the House of Delegates and other authorities of the American Medical Association; . . .

* * *

From page 529:

2. The Reference Committee on Legislation and Public Relations in joint meeting with the Reference Committee on Miscellaneous Business considering these resolutions reported that the resolutions introduce no new principles not already accepted by this House at former sessions and ask only definite clarification and study by the Board of Trustees. The joint committee recommended the adoption of the resolutions.

Dr. Harry H. Wilson, California, presented the following resolutions, whch were referred to the Reference Committee on Legislation and Public Relations:

> Whereas, In the drafting of policies or contracts to cover medical and hospitalization services of nonprofit and other prepayment organizations it is of primary importance that the agreements or contracts shall make a clear differentiation of medical and hospitalization services that will permit physicians who give pathologic laboratory, x-ray laboratory, anesthesia or similar services, to maintain their physician-patient relationship and their own status as physician specialists; and . . .

4. The resolution presented by Dr. Lyell C. Kinney, California, at the Atlantic City session, June, 1942.

Resolutions on Improvement of Relations Between Physicians and Insurance Companies:

> Whereas, It is desirable that physicians and insurance companies coöperate to the fullest extent, especially in the interest of persons covered by health and accident insurance; and
>
> Whereas, A serious situation has arisen in the administration of certain health and hospitalization schemes

whereby medical services are being billed under the term "hospital services" and are being paid for by insurance companies, as they are labeled hospital services; and . . .

* * *

From page 530:

REPORTS OF STUDIES OF PLANS AND ADVICE IN AVOIDANCE OF DANGEROUS PATTERNS FOLLOWED EACH YEAR

In 1934, at the Cleveland session a resolution introduced by Dr. Albert Soiland, Section on Radiology, stated that some hospitals were doing "collective bargaining for x-ray business," to the detriment of their staff roentgenologists. The Reference Committee considered "the questions involved in the resolution as being primarily ethical rather than truly economic, and for this reason, while recognizing the evils, refrains from direct comment concerning them and recommends that the resolutions be referred to the Council on Medical Education and Hospitals for such action as its wisdom may indicate."

As a result of study by the Bureau of Medical Economics, the ten basic principles for guidance in the formulation of any method of distribution of medical service were presented to the House of Delegates at the 1934 annual session and approved by it as follows:

In 1936, at the Kansas City session of the House of Delegates, resolutions were introduced by Dr. Albert Soiland, Section on Radiology, titled Resolutions on Taking Steps That Will Result in Practice of Medicine Being Conducted by Physicians and Not by Hospitals:

> WHEREAS, Certain lay groups in this country are arranging for, or attempting to arrange for, the provision of diagnostic medical services along with and as part of hospital services; and
>
> WHEREAS, The provision of such diagnostic medical services must inevitably foster fundamental changes in the practice of medicine; and
>
> WHEREAS, The American Medical Association is of the opinion that the practice of medicine should at all times be confined to fully licensed physicians; and . . .

* * *

From page 531:

Resolutions also introduced at the 1936 session by Dr. Edward M. Pallette, California, titled Resolutions Disapproving Division of Any Branch of Medicine into Technical and Professional Portions, stated that certain lay groups are endeavoring to arrange for the provision of diagnostic medical service along with and as a part of hospital service and pointed out that such fundamental changes in the practice of medicine may well result in deterioration of our present medical standards and especially in deterioration in the quality of medical care furnished to hospital patients and that it is the official policy of the House of Delegates that it disapproves of the division of any branch of medicine into technical and professional portions. It directed also that the resolutions be brought to the attention of the American Hospital Association and its affiliated groups to the end that existing arrangements permitting division in medical practice be terminated as speedily as possible.

* * *

When one reads and ponders on the above, the conclusion may be reached, perhaps, that in the far Southwest the medical profession is not so backward after all.

U. S. Casualties Total 90,860

Washington, June 24.—Total Army casualties for the entire war to date number 63,958, Secretary of War Henry L. Stimson announced today.

Total Navy, Marine Corps and Coast Guard casualties announced to date are 26,902, making the grand total 90,860.

The Army casualties comprise 7,528 killed in action or dead of wounds, 17,128 wounded, 22,687 missing, and 16,615 prisoners of war.

The Philippine campaign was the most expensive to date in casualties, owing to the large number captured and missing after the fall of Bataan and Corregidor.

Total casualties in the Philippine campaign were 31,610, including Philippine Scouts. There were 1,273 killed, 1,746 wounded, 17,939 missing and 10,652 prisoners.

The North African campaign cost 18,738 casualties—2,574 killed, 9,437 wounded, 1,620 missing and 5,107 captured.—San Francisco *News*, June 24.

EDITORIAL COMMENT†

DIETARY BLOOD DESTRUCTION

Five years ago it was shown by Johnson and Freeman[1] of the University of Chicago that, following a heavy fat meal, the thoracic duct lymph of dogs becomes markedly hemolytic. Fatty acids and soaps, which had presumably escaped resynthesis into neutral fats, were subsequently[2] shown to be present in this lymph in sufficient quantities to account for this hemolysis. Although this lymph empties but slowly into the blood stream, after a heavy fat meal the circulating red blood cells do become exposed to a sufficient quantity of these dietary hemolysins to cause increased fragility of canine erythrocytes,[3] and increased excretion of degeneration products of hemoglobin.[4] Other investigators have demonstrated a similar postdietary blood fragility in man.[5] Two glasses of cream are sufficient to cause accelerated blood destruction in a normal adult.[6] Although this dietary blood destruction is presumably insufficient to produce anemia in normal individuals, it may be a factor of considerable clinical importance under certain pathological conditions. This latter possibility is now under investigation.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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3. Longini, J., Freeman, L. W., and Johnson, V.: Fed. Proc., 1:51, 1942.

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5. Josephs, H. W., Holt, L. E., Tidwell, H. C., and Kajdi, C.: J. Clin. Invest., 17:532, 1938.

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Contract Let for New U. S. Hospital

Award of a $2,100,000 contract for construction of a $4,000,000 Army general hospital at Van Nuys was announced today by the U. S. Engineer office. It will be one of the largest Government hospitals for Army personnel in Southern California.

The hospital, which will accommodate 1,700 beds, will be ready for occupancy in four months, the engineers estimated. Total cost of the project will be approximately $4,000,000.

The construction will be of a permanent frame type of stucco exterior and plaster interior finish. It will consist of more than 100 buildings, including housing for officers, nurses and administrative personnel.

Included in total cost are kitchen equipment, hospital equipment, furniture and other materials costing approximately $1,000,000, it was announced. All materials have been procured.

Work is to begin at once.—Hollywood *Citizen-News*, June 16.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

Scientific and General

GASTRIC RESECTION FOR PEPTIC ULCER*

John W. Cline, M. D.
San Francisco

TWENTY years ago the acrimonious debate concerning the superiority of medical or surgical treatment of peptic ulcers occupied a prominent place in the literature and in medical meetings. The contentions of the internists and surgeons both had merit. They have now been reconciled, and opinions relative to the proper spheres of medical and surgical treatment have reached substantial agreement.

Duodenal ulcer is now considered to be primarily a medical problem. About 80 per cent of patients will respond to adequate therapy.[1] The remainder will develop complications, or their ulcers will prove intractable to medical treatment, and surgical intervention will be necessary. A larger proportion of ulcers of the stomach demand operative procedures due to the greater difficulty of accurate diagnosis, the hazard of malignancy and the need for more certain evaluation of the response to medical treatment.[2]

ETIOLOGY

The exact etiology of peptic ulcers has not been established. There is no complete explanation of the occurrence of ulcers and their recurrence after supposed complete healing under proper care. No adequate reason for their association with severe burns,[3] certain brain lesions [4] and other conditions has yet been conclusively demonstrated. Since the work of Sippy and others in the clinical care of ulcers, and the experimental work of Mann and Williamson,[5] and others, evidence has been progressively accumulating to give prominence to the acid factor in causation and maintenance of ulcers. The recent experimental production of ulcers in animals by the intramuscular implantation of histamin in beeswax has served to emphasize its importance.[6, 7] Certain hygienic, nutritional, and psychological influences demand attention and correction, if possible, but principal surgical interest centers about the acid levels. Until the entire etiology of ulcers has been unfolded, we must direct our therapy toward control of this important factor.

BACKGROUND OF OPERATIVE PROCEDURES

Two decades ago, a variety of operative procedures was employed and to some extent the same situation pertains today. There is, however, increasing agreement that radical resection of the stomach is the operation of choice, except in acute perforations, and when certain technical considerations or extreme hazards indicate less extensive procedures. As the superiority of the radical operation has been demonstrated, the ranks of those advocating gastro-enterostomy, gastroduodenostomy, pyloroplasty and similar procedures have progressively diminished.

The physiological basis of radical resection lies in the fact that the level of free hydrochloric acid is determined by the number and activity of acid-secreting cells, and the freedom of regurgitation of duodenal contents into the stomach. Berger [8] has demonstrated that the parietal cells are found in important numbers only in the corpus and fundus, and that the former is larger and presents greater concentration of cells. The gastric phase of secretion results from stimulation by food in the stomach, and there is clinical and experimental evidence that the antrum and pylorus are important in this regard.[9, 10, 11, 12, 13] The duration of the gastric phase is limited by the emptying time of the stomach.[7, 14] The regurgitation of alkaline duodenal content neutralizes free acid.[15, 16, 17]

An operation, to effectively reduce acid levels, must, therefore, remove a large proportion of the acid secreting cells, eliminate the indirect influence of the antrum, decrease the emptying time of the stomach and provide free regurgitation of duodenal contents. This entails excision of the pylorus, antrum and a sizable portion of the stomach.

There is some question as to the amount of stomach which must be removed to achieve the best results. Hunt,[18] Walters [19] and others believe that hemigastrectomy will accomplish almost as satisfactory results as more extensive resections. Wangensteen [13] maintains three-fourths of the stomach must be excised to obtain the greatest benefit. These surgeons are accurate in their estimates of the amount of stomach removed. Wangensteen [7] and Hunt [18] have devised methods of measuring the stomach. We believe that many surgeons have a tendency to overestimate the amount of stomach removed and suggest the adoption of a uniform plan of measurement and record. The indefinite terms "partial," "extensive" and "subtotal" should be discarded, and the extent of resection should be expressed in the fraction of stomach removed.

We agree with Wangensteen [13] that the objectives of operation are: "(1) That it relieve the patient subjectively and remove the ulcer diathesis; (2) That it prevent recurrent ulcer; (3) That it do not compromise the future of the patient."

ON RESECTION OF THE STOMACH

As yet no treatment, operative or otherwise, has consistently fulfilled these criteria; but the closest approach has been made by resection of the stomach which has been sufficiently radical to produce achlorhydria.

It has been our plan to remove two-thirds of the stomach in most cases. Occasionally, particularly in the case of high gastric ulcers, we have removed more. Our purpose is to remove enough of the stomach to secure at least a relative achlorhydria. The importance of the acid factor rests on such a firm experimental and clinical background that unless this is accomplished we believe the ultimate result to be jeopardized. A number of recent contributors have stated or implied that the occurrence of peptic ulcer in the human is primarily dependent upon unneutralized hypersecretion by the stomach.[20, 21, 22] It has been said that experimental ulcer has never been consistently produced except by methods which prevent neutralization of the acid chyme,[45] and that no clinical ulcer has been demonstrated conclusively in the presence of actual achlorhydria.[21] Even if these statements be not entirely accurate, they emphasize the importance of controlling the free hydrochloric acid level.

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* From the Department of Surgery, Stanford University Medical School (the Stanford University Service at the San Francisco Hospital) and the Department of Public Health, San Francisco, California.

Read before the Section on General Surgery at the seventy-second annual session of the California Medical Association, Los Angeles, May 2-3, 1943.

Table 1.—*Gastric Resection for Peptic Ulcers (1939-1942*)*

	Number	Deaths	Mortality Per Cent
Duodenal ulcers	47	5	10.6
Gastric ulcers	21	0	0
Gastrojejunal ulcers	11	0	0
Gastrocolic fistulae	4	0†	0
Total	83	5	6.0

81 two-thirds resections 2 limited resections
82 Polya (principally posterior) 1 Billroth I Anastomosis
A few duodenal ulcers left *in situ.*

* To October 1, 1942.

† One patient died of pulmonary tuberculosis two months after resection.

CLINICAL MATERIAL ON STANFORD SERVICE

During the past four years, eighty-three patients on the Stanford Surgical Service of the San Francisco Hospital have been submitted to extensive resection of the stomach for peptic ulcer. Eighty-one had resections of two-thirds or more of the stomach. One Billroth I anastomosis was made, the remainder were of the Polya type. A majority of these were retrocolic, but recently a majority have been anterior anastomoses. The anterior method allows removal of more stomach with ease of subsequent suture, and adds to the facility with which the operation can be accomplished. No entero-anastomoses have been made. These divert alkaline duodenal contents and sacrifice the advantage of neutralization of the acid secreted by the remaining stomach.

Suture methods have varied, but usually the full width of the stomach has been sutured to the jejunum with external rows of interrupted silk and internal continuous rows of fine chromicized catgut. The Hofmeister technique has been used in some cases.

The pylorus and antrum have been removed in all cases. We feel that the experimental work of Wangensteen and others, and the poor clinical results of the Finsterer technique make this necessary. If technical considerations interfere, we believe it wiser to perform a two-stage operation, as advocated by McKittrick [23] rather than the Devine operation [24, 25] or the mucosal resection of Bancroft.[26] It is important, when possible, to remove gastric ulcers and desirable to do so with duodenal ulcers. There is no great harm in leaving a duodenal ulcer, which is not actively bleeding, *in situ.* Even with much less radical procedures these ulcers heal. This is preferable to the hazard of attempting excision of ulcers in certain cases. The fatal outcome of two and perhaps three of the cases in this series might have been avoided by exercise of better judgment in this matter. One common duct injury followed by bile peritonitis and the perforation of an ulcer which had been too extensively freed before it was realized that removal would endanger the common duct account for two cases.

We place 8 to 12 grams of sulfanilamide in the abdominal cavity and wall prior to and during closure. We believe this has reduced our complications, particularly wound infections.

INDICATIONS FOR OPERATION

Gastric resection is indicated for the complications of duodenal and gastric ulcers, and those resulting from previous surgical procedures. In some instances the indications are absolute, in others relative, and, occasionally, subject to controversy. The most controversial indication is "intractability," as a result of widely varying individual interpretation.

Our cases have been classified according to the predominant indication, when such was present. When two or more indications existed, the case was tabulated as intractable. The indications for opera-

Table 2.—*Distribution of Cases*

Type	No.	Male	Female	Age	Duration of Symptoms	Gastric Analyses
Duodenal	47	43	4	36-64, Av. 52	2 wks. (?)-50 yrs. Av. 9½ yrs.	F 0-154, Av. 91 T 20-160, Av. 107
Gastric	21	17	4	36-77, Av. 51	1 mo.-28 yrs. Av. 8½ yrs.	F 34-124, Av. 72 T 48-137, Av. 99
Gastrojejunal	11	11	0	35-55, Av. 47	Prior to G. E. 0-23 yrs. Av. 5½ yrs. Gastroenterostomy 1-25 yrs. Av. 14½ yrs. Asymptomatic 0-19 yrs. Av. 5½ yrs. Recurrent symptoms four wks. 9 yrs.	F 38-90, Av. 61 T 60-106, Av. 81
Gastrojejunocolic Fistulae	4	4	0	41-72, Av. 53	Prior to G. E. 0-21 yrs. Av. 7 yrs. Asymptomatic 1-12 yrs. Av. 7 yrs. Recurrent ulcer symptoms 0-16 yrs. Av. 4 yrs. Diarrhea 1-4 mo. Av. 2 mo.	F 0-16, Av. 6 T 20-40, Av. 27

tion have been classified as: Hemorrhage, pyloric obstruction, perforation, intractability, gastrojejunal ulceration and gastrojejunocolic fistula. Hemorrhage has been further subdivided into acute, recent and previous recurrent massive groups.

Table 3.—*Indications for Operation*

	Hemorrhage					
	Acute	Recent	Previous Recurrent	Perforation	Obstruction	Intractability
Duodenal	5	8	5	3	11	17
Gastric	2	6	2	2	1	8

Hemorrhage.—Bleeding in some degree is inherent in all gastric and duodenal ulceration. Significant gross hemorrhage occurs in 25 to 35 per cent of cases.[27, 28, 29, 30] We consider massive hemorrhage that which produces sizable gross hematemesis, tarry or bloody stools, or both, associated with faintness or loss of consciousness, rapid pulse, fall in blood pressure, and marked reduction in hemoglobin and red cell count.

Those patients admitted to the hospital because of active bleeding of this type, and who were submitted to operation in the first few days for the purpose of arresting hemorrhage, are listed as cases of acute massive hemorrhage. Those who had experienced massive hemorrhage shortly prior to admission to the hospital, or who were admitted while bleeding, were carried beyond this phase by conservative means and then submitted to operation, are considered as cases of recent massive hemorrhage. Patients who had bled importantly on more than one occasion in the past but who had no recent history of gross bleeding are classified as previous recurrent hemorrhage.

We agree with the opinion of other observers that acute hemorrhage in patients below the age of forty-five should usually be treated by conservative means. Generalization is dangerous and each case should be considered individually. It is our experience and that of others that an occasional young patient will die of exsanguination, but the mortality rate of medical treatment will probably not exceed 5 or 6 per cent.[29, 31] This is lower than reasonably could be expected if all patients in this group were submitted to operation. It is occasionally necessary to operate upon a young patient who continues to bleed or has repeated hemorrhages. The decision is one which requires careful consideration and experienced judgment.

Patients beyond forty-five years of age must be viewed in a different light. Those in this age group stand hemorrhage from any source less well than younger persons. The bleeding vessel has a thicker wall which retracts less well and may be a rigid calcified tube in which effective thrombus formation is difficult. The mortality rate of conservative treatment in these patients is high, probably about 30 per cent,[1, 29, 30, 31] and is higher than would be expected from operation uniformly applied to this group.

These patients should be observed by the surgical staff from the time of admission, and unless there is evidence of prompt and complete arrest of hemorrhage, operation should not be long delayed. We agree with Allen, Walters, Finsterer[32] and others that operation should not be delayed much beyond forty-eight hours. If permitted to continue, hemorrhage will produce anemia, anoxemia of the tissues, lowered blood proteins, tissue edema, and malnutrition which greatly increase the risk.

When a patient who has not had a previously established diagnosis of ulcer enters the hospital, acutely bleeding from the upper gastro-intestinal tract, the surgeon is confronted by a difficult decision. If the patient is in the older age group, operation may be indicated for arrest of hemorrhage, but it is this same group which presents the majority of other causes for hemorrhage. The percentage of diagnostic errors is high. It can be reduced in some degree by carefully performed x-ray examination,[33] which may reveal an ulcer or esophageal varices. We have operated upon a few cases in which no ulcer was present.

Generous use should be made of transfusions whether patients are treated conservatively or radically. The widespread belief that the elevation of blood pressure due to transfusion may displace the clot in a vessel which has recently bled may have had some basis in fact but, at best, it must be rare. We have not encountered it even with the older, more rapid methods of transfusion. In fact, our experience has been to the contrary. We do not advocate transfusion of an actively bleeding patient unless this is urgently required, because the transfused blood may be lost, although we have seen patients apparently cease to bleed during or immediately following such transfusions. In eighty cases in which the blood pressure was above shock levels the average rise in systolic pressure caused by administration of 500 c.c. of blood was less than 5 mm. of mercury. This cannot be looked upon as a dangerous increase, and the value of transfusion in a patient suffering from the acute anemia of severe hemorrhage cannot be denied. With the increased availability of blood due to blood banks, we are using transfusions to an ever greater extent, before, during and after operation.

We have submitted seven patients to gastric resection during the actively bleeding phase, with one death.

Operation can be more safely performed after a patient has recovered from the effects of hemorrhage and has restored his hemoglobin, proteins, and nutrition. Operation must be considered in those patients who have had massive hemorrhage and have recovered from it. This is especially true when the hemorrhages have been repeated. The more frequent the hemorrhages in the past, the greater the likelihood of future bleeding.[34] A fairly large number of patients bleed once without previous or subsequent ulcer symptoms. These hemorrhages may come from acute, superficial ulceration which responds well to medical therapy. With repeated hemorrhages, and particularly in the older patients, the ulcer tends to be deeply eroding, and usually produces other symptoms as well. The prospect of success with conservative treatment is poor, and these patients usually should be operated upon.

In this series there were fourteen instances of operation for recent massive hemorrhage and five for previous recurrent hemorrhage.

Pyloric Obstruction.—Cicatricial stenosis of the duodenum or pylorus of sufficient degree to interfere with emptying of the stomach is frequently seen in long-standing ulcers. It is more common in elderly patients and may be seen in the absence of other recent ulcer symptoms. It should not be confused with the obstruction resulting from edema surrounding an active ulcer, which may subside under proper medical regimen. Many ill-advised gastro-enterostomies have been performed in the past for this type of obstruction. Some degree of cicatricial stenosis and active ulceration are frequently present simultaneously. In these instances the ulcer is usually of the posterior penetrating type and operation is indicated.

Patients with obstruction often present low acid levels. The combination of obstruction, low acid, and the fact that a large number of these patients are elderly have influenced many surgeons to perform gastro-enterostomies in this group and some still advocate this procedure as the operation of choice. At first glance the problem appears to be one of providing an adequate mechanical outlet for the gastric contents.

Our experience has been that these patients get along very well for variable periods after gastro-enterostomy, but in a number, the subsidence of the associated gastritis [35] causes higher acid levels to return and these patients contribute importantly to the incidence of marginal ulceration. It is, therefore, our opinion that unless there is contraindicating systemic or technical consideration, these patients should be given the benefit of radical resection.

Perforation.—Our usual practice is to treat acute perforations by simple closure after taking biopsies of lesions not clearly distal to the pylorus. Occasionally, one encounters large callous ulcers which make closure difficult or in which closure obstructs the pyloric outlet. Five patients, three with duodenal and two with gastric ulcers were submitted to resection at the time of acute perforation. In all instances indications additional to acute perforation were present. We believe the less done to patients at the time of perforation the better, but in the occasional case which requires some procedure in addition to suture of the ulcer, resection is preferable to gastro-enterostomy.

Intractability.—This classification is the largest of both the duodenal and gastric ulcer groups. Many duodenal ulcers present long histories with multiple symptoms. In such cases, when no one complication was predominant, and when some medical treatment had been employed, the case was classified as "intractable." Very few patients were submitted to operation solely because of subjective symptoms which were sufficiently aggravated that "they could not live with their ulcers." The patients in this series were faced with economic and social limitations which interfered in some degree with proper medical care. Educational deficiencies, alcoholism, and a lack of interest in pursuing medical treatment all contribute to the development of complications and the advisability of operative procedures.

The same circumstances pertain to the care of the patients with gastric ulcer, but the additional factor of malignancy occupies an important place. It is at times very difficult to determine whether an ulcer of the stomach is benign or malignant.[2, 36, 37, 38, 39]

The duration of symptoms, the size of the ulcer, its position in the stomach, its x-ray and gastroscopic appearance, the acid levels, and response to therapy all give valuable information, but occasionally, when all the evidence points toward a benign lesion, malignancy may still be present. A preoperative diagnostic error of 14 per cent after careful study has been reported by competent observers.[38] To a lesser extent, when the preponderance of evidence favors malignancy, a benign ulcer may be found, but this is of prognostic significance only.

A short history favors malignancy but does not rule out a benign lesion. It has been demonstrated that a majority of ulcers more than 2.5 cm. in diameter are malignant but 10 per cent of those with craters of less than 1 cm. are carcinomatous.[38] Ulcers of the lesser curvature and posterior wall tend to be benign and those elsewhere malignant.[30, 32] This is especially true of the greater curvature. Normal or increased acid values favor benign ulceration, but are commonly found in association with so-called "ulcer cancer" [38, 39, 40] X-ray and gastroscopic diagnoses are usually accurate, but are occasionally misleading, and more frequently inconclusive, even when made by experienced trained observers.

Most malignant ulcers have been carcinomatous from the start, but it has been fairly well demonstrated that certain long standing benign ulcers become malignant.[40] The number is certainly smaller than the original figures of McCarty, and may be smaller than the more conservative estimate of Stewart.[44] However small, it still requires consideration.

The preoperative differential diagnosis between benign and malignant ulcer is often extremely difficult. It is occasionally hard for the experienced surgeon to distinguish between them at the operating table, and the final diagnosis must be determined by microscopic examination.

Under these circumstances the indications for surgical intervention must be liberal. It is our opinion that a patient in whose case the majority of factors (*i. e.,* history, location, size, x-ray and gastroscopic appearance of the ulcer and acid levels) do not strongly indicate a benign lesion, should be submitted to operation at once. In those instances in which the evidence is predominantly in favor of a benign ulcer, the patient should be treated medically for a limited trial period, usually four weeks. If, in this time, improvement is observed as judged by symptomatic relief, diminution in the size of the ulcer by x-ray and gastroscopic evidence of healing, conservative therapy should be continued. If not, or if there is subsequent interruption of progress, operation should not be delayed. Patients who respond favorably to medical care should be kept under close observation for long periods, and in the event of recurrence, operation should be seriously considered. It must be borne in mind that carcinomatous lesions may give evidence of protracted improvement under medical therapy.

Eight of the twenty-one cases of gastric ulcer were submitted to operation primarily because of doubt as to diagnosis or failure to respond to medical treatment.

Gastrojejunal Ulcers.—Most observers believe that gastrojejunal ulcers should be treated surgically. We agree with this point of view in general. The complications of marginal ulcers are serious. Most of these ulcers have gross hemorrhage. Free perforation is very difficult to deal with, and gastrojejunocolic fistula presents a major technical and nutritional problem. The frequency of marginal ulcers is probably greater than generally appreciated. It is usually the more serious ones which come to our attention. The findings in this series indicate that stomal ulcers may heal, recur and again heal, leaving comparatively little trace. Under certain circumstances medical treatment is justified, but in the majority of instances surgery should not be delayed long after establishment of the diagnosis.

Gastrojejunocolic Fistulae.—The indication for surgery in gastrojejunocolic fistulae is absolute.

PREOPERATIVE PREPARATION

When time permits, as it does in elective cases, the patient should be carefully studied prior to operation. The risk of operation in the presence of chronic cardiac, vascular, renal or pulmonary disease must be evaluated, and balanced against the advantages of operation. Patients requiring operation often present rather marked nutritional disturbances. Adequate attention must be paid to anemia, dehydration, depletion of proteins and electrolytes, and avitaminosis. The usual oral or parenteral methods of restoring these lacks should be employed. We would like to stress the value of preoperative transfusions in the prevention of shock at the time of operation.

The stomach should be empty at the time of operation, and a Levine tube left in place during operation. In the presence of obstruction the stomach should be lavaged daily during the time of preparation, and constant suction applied for 24 to 48 hours immediately preceding operation. We have recently been lavaging the stomach with sulfanilamide just prior to operation. This probably has considerable value in cases of carcinoma, but seems superfluous with ulcers.

Patients with gastrojejunocolic fistulae are placed on succinysulfathiazole prior to operation, and preliminary colostomy in the ascending or right transverse colon is made after the plan of Pfeiffer.[42] The improvement of patients following this procedure is remarkable.

POSTOPERATIVE CARE

Continuous suction is applied to the Levine catheter and maintained for about seventy-two hours. Audible peristalsis has usually been reëstablished by that time. The stomach is then aspirated, a measured amount of fluid, usually 300 c.c., is introduced and the tube clamped. The stomach is reaspirated at the end of three hours. If more than half of the fluid has passed out of the stomach, the tube is withdrawn and feeding by mouth cautiously begun. The diet is increased in amount and variety gradually. The patient is usually taking a soft, well-balanced diet within ten days of the time of operation.

The Levine tube has great value in the immediate postoperative period, but it presents disadvantages. Practically all patients complain of its presence, and not infrequently the "sore throat" resulting from the use of a tube constitutes the major discomfort of the convalescence. It may well increase the incidence of pulmonary complications and parotitis. Protracted use causes ulceration of the pharynx or esophagus. During the past year every patient coming to post mortem on our Service, from whatever cause (carcinoma, intestinal obstruction, peritonitis, etc.), in whom a tube had been employed for more than a few days, presented such ulceration. One patient in this series developed a stricture of the esophagus which was presumably benign, and possibly the result of protracted use of a Levine tube. Another factor of importance is the size of the tube. There is a tendency to use the larger tube because of the greater ease of passage and less frequent stoppage. We believe the smaller 12 F and 14 F to be less dangerous than the 16 F tubes.

Coller and Maddock[44] have demonstrated that the average postoperative patient, whose temperature is not high and who is experiencing no unusual fluid loss, requires 2,000 to 3,000 c.c. of fluid per day. One liter of normal saline and two of 5 or 10 per cent glucose in water cover his fluid and electrolyte requirements. Any deficit produced by gastric suction must be covered. Fluids, and particularly salt solution, in amounts greater than required, lead to production of edema and should be avoided. In cases of protracted parenteral intake the other electrolytes must be supplied. Special care should be observed in the amount and speed of administration of fluids to elderly patients and those with cardiac, vascular or renal disease.

Careful attention should be paid to blood chlorides and proteins. More than the usual requirements in vitamins should be provided parenterally until the patient is able to take them by mouth.

We have frequently used the oxygen tent in the early postoperative period with gratifying results.

We urge patients to follow an adequate but somewhat restricted diet for a long period. We advise frequent meals of a bland type containing little which would produce mechanical or chemical irritation. It is our belief that this regimen adds to the prospect of maximum benefit from operation. A small number of patients follow this advice but a majority shortly resume diets and habits of their own preference.

RESULTS

Five patients in the group died in the postoperative period. The cause of death in one was massive bilateral pneumonia. This was prior to the time of effective chemotherapy. One died of hemoplegia. Three deaths were due to technical errors or errors of judgment which can be avoided in the future. The overall mortality of 6 per cent is not unduly high for patients of the type we are called upon to treat in our hospital, but should and can be improved.

The ultimate evaluation of any gastric operation requires many years. It has not been uncommon for patients to be well for twenty years or more after gastro-enterostomy, and then develop serious complications. Gastric resection has not been performed upon a large enough number of cases over a sufficiently long time to justify some of the claims which have been made for it. We already know that it is not a certain guarantee against marginal ulceration, and it is probable, just as it was with gastro-enterostomy, that the incidence is greater than we suppose. It has been reported to be as high as 8 per cent,[43] but most observers consider this an unusual circumstance.

It can be safely said, however, that the early results are far superior to those of any other operative procedure, and evidence indicating that the same will be true of the late results is accumulating.

The follow-up in this series leaves much to be desired. Most of the patients have been followed for at least one year. During this period the results have been excellent on the whole. A number of patients complain of fullness, discomfort, cramps, and occasional diarrhea after large meals. The major portion result from dietary or alcoholic indiscretions.

Some patients have subsequently reëntered the hospital for unrelated reasons. These patients have all had good results. Three have been admitted for gastro-intestinal symptoms. One of these had a marginal ulcer one year after resection for gastrojejunocolic fistula and has been well since a secondary resection. One was discharged, symptomfree, after negative investigation, and one was discharged three days after admission for gastric symptoms associated with alcoholism.

Not all of the patients were submitted to postoperative gastric analysis, but only two patients with free hydrochloric acid to single histamin stimulation were found. One of these was the gastrojejunal ulcer referred to above, and the other a patient submitted to limited resection.

SUMMARY AND CONCLUSIONS

1. A series of eighty-three cases of resection of the stomach for the complications of peptic ulcer is presented.

2. The indications for operation, preoperative preparation, operative procedure, postoperative care and results are discussed.

3. Resection of two-thirds of the stomach, including the pylorus and antrum, is based upon sound physiological principles, and is the operation of choice in most cases of peptic ulcer requiring surgical intervention.

490 Post Street.

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Navy to Expand Coast Hospital Chain

Rear Admiral Ross McIntire, personal physician to President Roosevelt and surgeon general to the Navy, today in a press conference here announced plans for huge expansion of Navy West Coast hospital and convalescent facilities. . . .

He stated a temporary hospital will be erected at Astoria, Ore., for men in the air arm of the Navy stationed along the Oregon coast.

The Navy plans to have 60,000 hospital beds available by the end of the 1944 fiscal year, and another 20,000 by the end of 1945 fiscal year, all within the continental limits of the United States, he said.

Asked why Navy physical standards had been lowered, he said manpower for the Navy was low and that the Navy now planned on taking in men for limited duty to relieve others for sea duty.

Admiral McIntire praised the mobile base hospitals in the South Pacific, pointing out that the death rate was very low among the wounded.

He said medical cases in this war are much different from those of the last World War because of the extreme violence in the present conflict. . . . —San Francisco *News*, June 2.

WELDING FUMES AND GASES: THEIR EFFECTS ON THE HEALTH OF THE WORKER*

John Brodie, M. D.
Wilmington

In the present war effort, particularly in the building of ships, the process of welding has become so important as to be almost indispensable. It is, therefore, timely and opportune to speak of the effects of the fumes and gases, generated in the process of welding, on the health of the welder and his associates.

DANGERS TO THE WELDER IN MODERN ARC WELDING

Now, in modern arc welding there are at least three sources of danger to the worker. The first is that from the arc itself, where the temperature may reach over 6,000 degrees Fahrenheit. Such tremendous heat may be responsible for burns which heal but slowly. Besides this, the intense ultraviolet rays generated may produce eye-flashes, which are only too common. Then there is the hazard that arises from the presence of ozone, which is formed from the oxygen around the arc. The arc is also responsible for the nitrous fumes, which are generated by the combination of the nitrogen and the oxygen of the air. These so-called nitrous fumes consist of a varying mixture of the monoxide of nitrogen, the dioxide, the trioxide, the tetroxide, and the pentoxide, as well as nitrous and nitric acids. Of these, the dioxide is the most stable.

Coming now to the second source of danger, namely, the rods and their coverings, we have to take into account the production of not only the particulate fumes of iron, but also the fumes of any other metals and substances that enter into the composition of the rods. To mention only a few of the known metals, there are manganese, chromium, cadmium, nickel, zinc, and magnesium, each of which may produce its own symptoms of poisoning. The coating of the rods introduces further possible hazards from such substances as fluorides, silicates, varnish, rubber, etc.

Finally, we must not forget the factor of oxygen deficiency, particularly if the welding is done in a confined space where the ventilation may be poor.

CLINICAL ASPECTS

Turning to the clinical side of the problem, we may ask, what are the commonest and most outstanding complaints for which welding might be held responsible? About this there still exists much difference of opinion, and I believe that the best way to answer this question is to present the histories of some of the cases of welding fume and gas "poisoning" that I was able to study during July and August of 1942. As there is a notable lack of case reports in the literature, such histories may also prove interesting.

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* Paper based on a study of patients referred to the office of R. W. Stellar, M. D., at Wilmington, California. Prepared for a group of physicians, surgeons, and others interested in the health of some 40,000 shipyard workers in Southern California.

REPORT OF CASES

Case 1.—F. D., age 34. Pipefitter at the shipyards for the last four months. His story was that last night, after he had got home from his work of cutting galvanized pipes with the electric arc, he felt an aching in his bones and in his head. He became conscious of a tight feeling in the chest, and began to cough, but was unable to raise any phlegm. Then he got a shivering chill, which was followed by feverishness. All this he ascribed to the fumes from welding galvanized pipes, because he was told by his fellow workers that those were exactly the symptoms of "galvanized poisoning." He was sure that the galvanized fumes must have been responsible, because six weeks ago, after cutting 65 feet of galvanized pipe, he also developed a dry cough and a tightening in the chest. He stated that he wore a hood at his work, but no respirator or mask. Examination showed a very muscular, stocky individual, lying in bed at home, and appearing very nervous and irritable. He had been a professional weight-lifter, and was obviously anxious about losing his cherished strength as a result of "galvanized fumes." His temperature was 100. His throat was only slightly reddened, and his heart, lungs, and blood pressure were normal. An x-ray of the chest, taken a day later, was negative. This was such a relief to him that he immediately returned to his work. You may wonder whether this man's symptoms were due to metal fume fever, or was he developing an attack of "flu" or grippe. The important point to note is how quickly he recovered from his attack. This rapid recovery is in favor of a diagnosis of metal fume fever.

* * *

Case 2.—W. N. T., age 36. Pipefitter at the shipyards for the past four months. Before this he was a pipefitter in the oilfields. He states that he has not been well for the last three months. His story is that three months ago, after a hard day's work at cutting galvanized pipes with the electric arc, he developed a shivering attack. Then he felt feverish. Next morning his throat felt very sore, and he began to have a dry cough. On the following day, he developed a cold in the head with headache and running nose. After two weeks, his throat got better, but his cough has persisted. Even now he has such violent bouts of coughing, with raising of brown phlegm, that he becomes nauseated and gets a pain in the pit of his stomach. Although his appetite is good, he says he has lost ten pounds in the last three months. On examination, coarse expiratory râles can be heard in the chest, and the x-ray film shows much peribronchial thickening. In considering the etiology of this case of bronchitis, shall we say that it is due to the inhalation of galvanized fumes, or that it is the result of an upper respiratory infection? He says that he is not subject to colds, but metal fume fever is not usually followed by a persistent bronchitis such as he has had.

* * *

Case 3.—J. O. R., age 23. Has been a ship's painter for the last six weeks, and before that he was a buffer. A month ago he began to have night sweats, his appetite became poor, and he has been losing much weight—close to ten pounds. He has had a cough for seven weeks, and raises a reddish sputum which he thinks is due to red lead and dust. There has been no nausea or vomiting. During the past three weeks he has often felt weak and dizzy, and he sometimes sees spots before his eyes. He says he wears a respirator, but he thinks it is of no use because the filter is not thick enough. If it were thick enough, he argues, it would interfere with his breathing. In considering this case, it may be asked which was the original cause of his symptoms, his present work as a ship's painter or his previous work as a buffer? In any case, the night sweats, the loss of weight, and the cough with reddish expectoration made me suspect tuberculosis; but a chest film was quite negative, and his temperature was normal. The sputum was not tested for tubercle bacilli.

* * *

Case 4.—K. R. C., age 33. For seven months he has been a combination welder, i. e., he welds sometimes with the electric arc and sometimes with the oxy-acetylene torch. Besides cutting galvanized pipes and welding steel plates, he also does bronze and aluminum welding. Before the war, he had a welding shop of his own. His story is that a week ago he began to ache all over, and last night he had a shivering chill which lasted three hours. He coughs little, but raises yellowish phlegm. When asked what he had taken for his prolonged chill, his answer was that he took atebran tablets. Interested, I asked him why he took those particular tablets, and his reply was that, while he was in South America, he caught malaria in 1939, and since then he has been subject to attacks, usually in the spring only, but occasionally in the fall also. If he took atebran tablets three times a day for three days he made a prompt recovery. He thought, however, that the chill he had a week ago was a little different, because he was not so feverish and did not perspire so profusely as in his usual attacks of malaria. His chest film was normal, but his liver was slightly enlarged and definitely tender. His spleen was not palpable.

* * *

Case 5.—E. W., age 34. During the last nine months he has been a welder at the shipyards, and before that he was a house painter and paperhanger. He states that two months ago, at 4 a. m., he woke up with choking and cough, but little expectoration. This attack lasted fifteen minutes. Similar attacks occurred every night for a week, but finally ceased with the help of Brown's mixture. Three weeks later he had another series of attacks for five nights in succession. Ten days ago he developed an ordinary cold with sore throat and running nose, and two days later he began to cough and bring up yellowish-white phlegm. This cough with expectoration has peristed, and he now complains of nausea, insomnia, and soreness around the lower ribs. An interesting feature is the fact that, four months ago, he noticed that whenever his wife swept the floor, he got an attack of sneezing. During such an attack he would sneeze twenty-five to thirty times, and then discharge much thin fluid from the nose. On examination, it was found that he had a few scattered bronchial râles on both sides, but an x-ray film of the chest showed only peribronchial thickening. His pharynx, however, showed the presence of a marked postnasal discharge, and there was a deflection of the septum high up in the nose. This case illustrates the fact that any upper respiratory disease, such as nasal, sinus, or throat trouble, makes a man peculiarly sensitive to welding fumes and gases which may produce a persistent and troublesome bronchitis.

* * *

Case 6.—R. R., age 57. Chipper. When I first saw him on July 15, he was obviously nervous, irritable, and antagonistic, but I was able to elicit the following story. On March 17, after one of the burners had been using an acetylene torch in the first watertank, he himself settled down to do his work of chipping. After working 2½ hours he began to feel dizzy. He, therefore, got out of the tank, sat outside for fifteen minutes, and then walked over to the field hospital. After receiving oxygen for one hour, he ate his lunch, sat in the sun, and slept for two hours. Then he returned to the field hospital where he inhaled more oxygen. At the end of the shift, at 4:30 p. m., he drove home in his car, a distance of some forty miles, ate his supper and went to bed. At 11 p. m. he suddenly woke up with shortness of breath and a rattling noise in his throat. Excitedly he told me, "I have heard that rattling in the throats of men before death, and I was scared, so I called my doctor." He was sent to the hospital where an x-ray of the chest showed a diffuse, soft, bilateral, and patchy infiltration of the lungs. An electrocardiogram, taken later, showed some depression of the T waves. Now, four months later, he complains of a shooting pain across the anterior chest, especially in the third intercostal space on the right, but shifting from place to place. He feels weak, perspires easily, feels nervous, is unable to sleep, and has become impotent. His only important previous illness was in December, 1940, when he was in the hospital for a month with double pneumonia. Examination showed a nervous, middle-aged man with coarse tremors of the fingers. His heart was only slightly enlarged to the left, but the rate was 110, and two minutes after exercise it was 124. There were occasional extra-systoles. His blood pressure was 170/98. A new film of the chest showed only peribronchial thickening. As it was known that his blood pressure had been normal a short while before, a diagnosis of neurocirculatory asthenia could be made. An electrocardiogram, taken again, showed signs of only mild coronary sclerosis. He was much relieved to know that his heart was not as bad as was thought. After taking a mild sedative, his blood pressure came down to 150/92, and the rate of his heart dropped to 100, and only 110 after exercise. He still had slight pain across the anterior chest on deep inspiration. By July 30, there was only a dull ache across the second and third interspaces, the cardiac rate was 90, and the blood pressure 140/90. He is now very coöperative, does not seem or feel nervous, and is going back to work. I suggested a lighter job, but he prefers his old job of chipping. In this case, I believe we may make a diagnosis of acute pulmonary edema due to the inhalation of a dangerous concentration of nitrous fumes. When he came to see me he had long recovered from this, but he had developed a distressing neurocirculatory asthenia with cardiac neurosis.

COMMENT

If we make a general analysis of these sample case histories, we can differentiate at least one general reaction to welding fumes and one local reaction to welding gases. The general reaction has been known for a long time, because it produces a definite and clear-cut picture. It is now known as metal-fume fever, but was formerly known as "metal ague," "zinc chills," or simply the "shakes." It is caused by the inhalation of the fumes of zinc, or rather the oxide of zinc. Thus, it is known that, in cutting galvanized pipes or welding sheets with the electric arc or the acetylene torch, a certain proportion of the operators and their helpers will develop metal-fume fever, because the galvanized coating contains over 95 per cent zinc. This is particularly liable to happen if the work is carried on in confined areas, such as tanks, boilers, or double bottoms of ships, where proper ventilation is difficult and often quite imperfect.

SYMPTOMS

The onset is acute, and the symptoms resemble an attack of "flu" or grippe. A typical attack begins after the man has left his work and gone home, *i. e.,* several hours after exposure to the fumes. Sometimes, even during exposure at his work, he may notice a metallic taste in the mouth and a dryness in the throat, as well as a feeling of nausea and tightness in the chest, which he may report at the time or before going home. After reaching home and going to sleep, he awakens with a shivering chill which often lasts one or two hours. He then feels feverish and breaks out in a profuse perspiration. His temperature is usually found to be between 100 and 102 degrees Fahrenheit. At the end of the attack he aches all over and feels exhausted. Such an attack is typically short-lived, and lasts only twenty-four to forty-eight hours.

An interesting feature is that these workers often develop a certain immunity or resistance if they continue at the same work. If, however, they get away from welding for a time, they rapidly lose this immunity. Thus, it happens that many of the older workers, having had one attack early in their career, never have another unless they leave this work and then return to it after an interval.

Such an attack may so resemble the onset of influenza that it is sometimes difficult to be sure whether we are dealing with metal-fumes fever, or an attack of "flu" or grippe. Of course, there is the history of exposure to zinc fumes, but not all workers thus exposed suffer an attack of zinc chills. As a matter of fact, the majority do not. It has been estimated that out of 100 workers regularly exposed to galvanized fumes, about 75 do not suffer at all. About 20 out of the 100 have chills occasionally, and only five have frequent attacks. Often there is no typical attack at all, but the patient complains of an annoying soreness of the throat, or of a dry, hacking cough that tends to persist. Sometimes the chief complaint is nausea, with or without vomiting, and loss of appetite. A common and very uncomfortable condition is a feeling of constriction or tightness in the chest, when every breath becomes an effort. Not infrequently the chief trouble is that after an acute attack the patient is left tired and weak, with no pep or ambition, but with a sense of nervousness which makes him feel unfit or indisposed to return to work for many weeks. Physical examination is usually negative, but the morale seems to be lowered. For want of a better name, I refer to these men as cases of *"welding-fume neurosis."*

REACTIONS TO GASES

Leaving the subject of metal-fume fever, which is an acute, general, and transient reaction to welding fumes, we now turn to the gases, and especially the nitrous gases, which are responsible for a local reaction in the lungs. This pulmonary reaction may be serious and even lead to death. What happens is this: After exposure to these welding gases, the worker has an acid taste in his mouth and begins to cough. If he then goes out into the fresh air, his condition may improve considerably; but five or six hours later the cough returns in a more intensive form, with shortness of breath, cyanosis, and a feeling of pressure in the chest. The patient thinks he is having an attack of asthma. This may be followed by acute pulmonary edema with profuse expectoration of foamy, yellowish, or pinkish fluid. Heart failure and death may follow in forty-eight hours. If the amount of nitrous gases inhaled is smaller, the patient may develop, not pulmonary edema, but pneumonia or acute bronchitis. An x-ray of the chest is useful in the diagnosis of pneumonia or of acute pulmonary edema, the latter of which shows a diffuse, generalized, and bilateral infiltration of the lungs with indefinite outlines, *i. e.,* the infiltration is of the soft exudative type.

The effects of nitrous gases may be so serious that it becomes important to ascertain how frequent is this hazard. Are many workers affected by it, or is it only a rare occurrence? And besides the immediate effects, what about the chronic results? Are these workers likely to suffer later on, in the course of years, from the slow but cumulative effects of the products of welding?

GASES: REFERENCES TO THE LITERATURE

In order to find a ready answer to these questions we had better turn to the literature, but here we find quite a diversity of opinion. Some writers believe that the hazard is both frequent and lasting, and go to the extreme of ascribing to welding almost any disease that may be found in a welder. They include a multitude of diseases as possible consequences of the welding hazard, such as tuberculosis and cancer of the lungs, ulcer of the stomach, lesions of the nervous system, aplastic anemia, and other dyscrasias of the blood. Even atrophy of the sex glands has been linked with welding. It is not surprising, therefore, that some physicians and, therefore, many patients, blame the fumes and gases for almost everything. However, it is obvious that these opinions are only speculations, and are certainly not supported by any scientific or experimental evidence. On the other hand, some firmly believe this occupation to be quite harmless, and one German writer convinced himself that welders are in better health than other workers in the same factory.

Here, then, we have the two extremes, and it must be admitted that this diversity of opinion is very confusing. This difference of opinion is due to the fact that conditions in different plants vary so much that there is no standard by which to measure or compare the results. Besides, the composition of the rods and their coatings may be very different. For this reason no one clinical investigator can speak with complete authority on this complex subject.

ANIMAL EXPERIMENTATION

So we had better turn to animal experimentation, where the conditions can be fixed or varied at will and the animals sacrificed afterwards, in order to find any changes in the tissues on postmortem examination.

It must be said at the outset that the number of experimental investigations is not great. It was, indeed, not until 1935 that the first experimental work on animals was done by Drinker[1] and his associates at the Harvard School of Public Health. This group of investigators exposed cats and rabbits to the welding fumes of bare uncoated iron rods and found that they all developed a severe inflammation and hemorrhage of the mucous membrane of the respiratory tract which, in some cases, resulted in fatal pulmonary edema. These effects were not due to the fume particles of iron oxide, which could be filtered out, but to the gases generated by the arc, namely, nitrogen dioxide and ozone. It must be remembered, of course, that the animals that died had been exposed to more than three times the concentration of gases found around a welder even in a poorly ventilated shop. It was concluded, therefore, that acute pulmonary edema, or pneumonia, is caused only when the concentration of gases is very high.

More recently, in 1940, Harrold, Meek, and McCord,[3] at the Industrial Hygiene Laboratories in Detroit, again investigated the simplest form of arc welding with washed bare iron rods, and found that the danger from nitrous gases was not as great as was formerly thought. They were not able to produce acute pulmonary edema in their animals, although they exposed them repeatedly for prolonged periods, but some developed pneumonitis. It was also found that the iron, and even the manganese, fumes were not specifically harmful, and that ozone, known to be irritant, was not present in the surrounding atmosphere in sufficient quantity to cause harm. Thus, the entire absence of pulmonary edema speaks well for this simple type of arc welding, so long as it is not carried out in confined spaces where the ventilation is imperfect.

As, however, no investigations had been carried out with coated rods, Hamm and Groom[4] of Ohio State University, undertook an experimental investigation of the pathological effects of coated or shielded rods on various animals in order to discover which coatings were toxic and which were not. They found that the incidence of serious lesions was relatively low, and that over 50 per cent of their animals survived without any harmful effects at all. Some of them became pregnant during the welding experiments and bore healthy litters. They did not lose weight, and showed no disturbances in their living habits. The low death rate of the animals, even when exposed to high concentrations of welding fumes and gases, can be taken as evidence of the low toxicity of the welding products; and at industrial concentrations, which are much lower than in these experiments, the hazard from modern welding with coated rods cannot be great. Some rods, however, namely, those containing fluorides, were found to be more toxic, and that is one of the reasons why the U. S. Navy has discouraged the use of such electrodes.

COMMENT

These investigators, therefore, drew the conclusion that in modern welding, which is usually done with coated rods, if precautions are taken to prevent the inhalation of high concentrations of fumes and gases, the risk to health is not great. There may be some irritation of the throat and bronchial tubes, but there need be no serious hazard to health even from prolonged and repeated exposure, so long as ordinary precautions are taken.

That exposure to welding fumes and gases, over a period of many years, produces no permanent functional impairment in welders was proved by Sanders of Milwaukee,[5] who, in order to controvert the conclusions of some English investigators, examined twenty-six welders with an average of nineteen years' work. As a result of his investigation, he was able to show that the lungs of welders do not appear to be more susceptible to tuberculosis. He also noticed that, as a group, welders are less susceptible to ordinary colds than other workers.

More recently, Gardner and McCrum[6] of Saranac Lake devised experiments to determine whether the susceptibility of animals to tuberculosis is increased by the fumes and gases of arc welding. They found that, even in guinea pigs, repeated exposures to ordinary concentrations did not increase the normal susceptibility of the animals, nor did such exposures reactivate any preëxisting, partially healed, pulmonary tubercles, or produce progressive tuberculosis.

PREVENTIVE MEASURES

However, most investigators caution that welding of any type should not be done in confined spaces, even for short periods of time, without taking certain precautions. We may now ask, what are these precautions? They are mainly a problem for the engineer, but the principle is simple. The fumes and gases must be prevented from reaching the worker. If possible, welding operations should be carried on in a closed process, or if that is not practicable, then a system of exhaust ventilation with hoods must be fitted over the process. A portable exhaust ventilator may also be used to remove the fumes at the source, and this ventilator can be carried along with the work from place to place. This is very convenient if the welding is done in confined or poorly ventilated places, such as tanks, boilers, or double bottoms. Special attention to ventilation is necessary in working with materials that have a high zinc content, like galvanized pipes, or if the steel contains cadmium, which is very toxic, or if the flux contains fluorides.

Respirators should be worn by the operators, particularly if the exhaust blowers are not quite efficient, or if, for some reason, they cannot be used. Apparently, for one reason or another, some of the men do not like to wear any respirators. It would be well, therefore, if talks could be given to the men, and particularly to the foremen and leadmen, in order to obtain their intelligent coöperation in the use of these safety measures. It is also important to remember that where metal sheets are covered with lead paint and have to be cut by the acetylene torch or by the electric arc, there is a serious danger of acute lead poisoning. These lead fumes, even if the concentration is small, must be kept away from the workers by blower and respirator and mask. For, while zinc oxide is promptly eliminated from the body and, therefore, produces no cumulative effects, lead is stored in the body and the effects are definitely cumulative.

DIAGNOSIS AND TREATMENT

And now a final word about diagnosis and treatment. As we have seen from the case histories, it is not always possible to make a diagnosis from symptoms and signs alone. In most cases very few signs can be found, even on thorough examination. Nor does an x-ray of the chest often show anything unusual. The physician will, therefore, have to make up his mind from a careful and critical consideration of the history given him by the patient. Often he will have to discount the inaccuracies, the exaggerations, and the misleading statements that creep into the patient's story. Only by obtaining his occupational history, as well as the exact nature and circumstances of his exposure, and then harmonizing these with the meager findings on examination, can the physician hope to make a fair and satisfactory diagnosis of the condition before him. Then he will have to treat not only the condition, but also the patient.

As for metal fume fever, which so mimics an attack of "flu" or grippe, there is no specific remedy, but the treatment may be similar to that of the "flu." Thus, aspirin, grains 10, may be given every four or six hours for the aches and pains; and, if there is a distressing dry cough, codein, grain one-half to one, may be added. In same cases, the inhalation of steam with tincture of benzoin compound seems to take the rawness out of the laryngeal, tracheal and bronchial mucous membranes. Patients have told me that such an inhalation seems to "touch the spot!" Occasionally, patients expressed a firm belief that a weekly steam bath, Turkish or Russian, helped them to get rid of the effects of the fumes on the chest. Morphine, however, should not be given, because of its depressant action on the respiratory center. Hot drinks are indicated, and fruit juices are useful unless the stomach is very irritable. Of course, the milder cases will not need any treatment, unless the patient shows much nervousness or anxiety about his condition.

Those patients who have possibly been exposed to nitrous gases in high concentration, such as may happen in small enclosed spaces, should be kept quiet for twenty-four hours, with medical attention easily accessible. This is necessary in case a serious emergency arises six or more hours after exposure. The inhalation of ammonia vapor obtained from the carbonate of ammonia has been recommended, but the inhalation of 5 per cent bicarbonate of soda mist seems more desirable. In anticipating pulmonary edema that might set in, it is well to maintain good oxygenation by giving oxygen for ten or fifteen minutes every hour or so. If pulmonary edema has developed, and the patient's face appears cyanosed, or the fingernails are definitely blue, a venesection of 500 cubic centimeters of blood may be life-saving. Transfusions or infusions should not be given, for fear of increasing the edema of the lungs. Morphine with atropine used to be a favorite and effective treatment for acute pulmonary edema. The result was often a cessation of the profuse watery and bloody expectoration, followed by a dramatic recovery; but it is now felt that morphine may depress the respiratory center to a dangerous level. Codein and barbiturates are considered safer. As for cardiac stimulants, it is best to do without them, or use them sparingly. Besides, oxygen and venesection will be found more useful. Even when the acute pulmonary edema has subsided, the patient has to be kept under observation for a few weeks, because of the possible late onset of pneumonia or the development of inflammation of the smaller bronchial tubes known as bronchiolitis obliterans.

PSYCHOLOGIC REACTIONS

Having treated the patient's illness, what about the patient himself? As I pointed out at the beginning, the patient seems to look upon galvanized fumes as a pernicious and sinister agent. He has, somehow or somewhere, been imbued with a deep suspicion and an exaggerated fear of the consequences of welding fumes. He will not do well or recover fully unless we can exorcise this exaggerated fear. If we fail to allay his fears, he is apt to develop what, for want of a better name, we can call a "fumes neurosis," and he will continue to feel exhausted, without pep or ambition. He will then become more and more indisposed to return to work. Although we call this condition a neurosis, strictly speaking it is most often a sort of hysteria. It is really an hysterical reaction to an accident by a person with an underlying neurotic personality makeup. In other words, the patient makes unconscious use of the accident or illness to solve his personality difficulties. I repeat that the patient is not aware of this trick, or alibi, played by his subconscious mind. It seems as if the accident brings to a head those inner and outer complexes which he has been unable to solve normally or face squarely. The accident is, indeed, a cause of this hysterical reaction, but only a precipitating cause, for the ground is prepared by his personality makeup.

It is also true that the expectation of compensation plays a rôle, but it is not the chief rôle; and it is important that the physician realize this, for such patients are sensitive and touchy. The approach to them must be psychological. It is not wise to declare bluntly that there is nothing wrong with them, for such a statement is neither convincing nor complimentary. It is better to take an x-ray film of the chest, because in most cases the patient has a lurking fear that the fumes have damaged his lungs. This film should be shown to the patient, and the heart and lungs pointed out, in order that he may be convinced that the fumes have not damaged those "vital organs." If he is still unconvinced, he should be shown a normal film side by side with his own. That should convince him, because "x-rays don't lie." A nerve sedative will do the rest.

IN CONCLUSION

We may conclude this paper by repeating that welding is not really a hazardous occupation, provided the concentration of fumes is kept at a low level. It may also be stated that although, after many years of welding, the lungs may show certain fibrotic or nodular changes which, in an x-ray film, may remind one of early silicosis, there is neither the shortness of breath nor the tendency to tuberculosis which is seen in silicosis. It is important that the physician realize the essential harmlessness of these so-called "spots on the lungs," so that he may be able to explain away the fears of his patient and reassure him honestly and effectively.

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HEALTH CONTROL IN WELDING*

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In the contract shipyards of the Maritime Commission and Navy we have today over a million employees. The yards themselves vary in size from a few thousand to 40,000. In many cases they are built on made land, and the workers are drawn literally from all walks of life. A maritime yard is lucky if it has more than a few per cent of workers who were shipbuilders before the war—the vast majority are green workers who have learned all they know about shipbuilding right in our yards since 1941. Jobs, such as welding, are about the same in all Maritime Commission yards, for there is little difference, from the health standpoint, in the way a freighter is built in Portland, Maine, in Houston, Texas, or in Portland, Oregon.

PRE-OCCUPATION EXAMINATIONS

On the East Coast, the Gulf, and on the Great Lakes, it is usual for new workers to be given preplacement physical examinations. In general, check-up examinations of men working on cranes, trucks, and the like are given at regular intervals; also jobs with possible occupational disease risk are checked from time to time. On the West Coast, however, the labor contract,[1] page 14, governing most of the region stipulates that:

"There shall be no doctor's physical examination nor age limit, except as required by law."

The Maritime Commission fully recognizes the validity of obligations existing under collective bargaining agreements, and with respect to physical examinations which would exist as a condition preceding employment, feels that the provisions in the Minimum Requirements for Safety and Health [2] do not present any direct conflict with the prevailing obligations of contractors on the Pacific Coast. The distinction must be made that the purpose of the physical examination provided for under the Minimum Requirements is based upon public policy directed toward insuring safe and competent workmen in particular jobs, and such examination is not a prerequisite for employment, occurring after employment but before placement on the job. This distinction should be borne in mind in considering the text of the recent Safety and Health Standards:

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* Guest speaker, presented at the seventy-second annual session of the California Medical Association at Los Angeles, May 3, 1943.

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> H-6. Examinations.
>
> 6.1. Physical examinations to insure proper placement of employees shall be given.
>
> 6.2. Periodic check examinations shall be given men working in occupations potentially hazardous to themselves or others, as for example, to crane operators, locomotive and hoisting and portable engineers. Periodic check examinations should be given men in jobs in which there may be health hazards, as for example, to sand blasters, radium and x-ray workers, and paint sprayers.
>
> 6.3. Special examinations such as x-ray, serologic and urinalyses should be given in the individual case as indicated and in accordance with local needs.

As these standards have been accepted by a national conference attended by representatives of management and labor in shipbuilding yards holding Maritime and Navy contracts and have been approved by the Navy and by the Maritime Commission, it is expected that, on a sound and practical basis, preplacement examinations on the Pacific Coast gradually will be extended as the necessary machinery and personnel become available.

OREGON STUDIES

Recently, Doctors Menne, Beeman, David, and Hunter of the Oregon Medical School investigated clinically some forty men and their working environment in the Oregon Shipbuilding Corporation † and published a report on their findings.[3] The yard employed, as of January 1, 1943, 32,843 workers. Of this number about 6,000 were welders, a normal proportion. As the Portland yard did not exist in 1940 and was about a year in building, most of the shipyard workers there, including welders, could not have had any extended shipyard experience. The report states (page 21) that the "length of service and, therefore, the possibility of exposure, usually varied from three weeks to eighteen months. Thirteen worked from one to six months, eleven from six months to one year, and the remainder from one year to a year and a half. A few were exposed for only a day or two."

The Menne report implies that further investigations are pending, but from the text of the published material, one must be satisfied with statements such as these (page 25):

> It is fair to assume in the study of a group of individuals of this kind that there is sufficient evidence to warrant the conclusions that occupational fumes, gases, and dusts—are sufficiently hazardous, in certain locations, to *per se* cause disease processes in the lungs and the air passages. It also seems to us that regardless of a possible difference of opinion as to the seriousness of such clinical diseases, the conditions causing them can and should be corrected.

The evidence which Menne presents that things are amiss, or that novel industrial diseases are present in the shipyards, is far from clear.

ON AMOUNT OF EXPOSURE TO WELDING FUMES

In the Portland yard—and it applies equally to other shipyards using welding processes in a substantial manner—at least half the workers have, in legal parlance, some exposure to welding fumes. It is timely, therefore, to discuss briefly the effects, upon man, of breathing such fumes. One of the oldest industrial maladies we have is metal-fume fever, otherwise known as zinc shakes, brass chills, brass ague, and more recently as galvo. In the manufacture of brass, metallic zinc is added to molten copper. The boiling point of zinc happens to be about 100 degrees centigrade less than the melting point of copper. Consequently, a copious evolution of zinc vapor results immediately on adding zinc to the molten copper. The zinc vapor burns to the yellowish white oxide of zinc, ZnO, which rises as a cloud.

Galvanized iron is iron or steel coated with zinc. The zinc is applied in such a manner that a fairly strong union or alloying between the two metals results. In ship construction we use a certain amount of galvanized metal to prevent too rapid corrosion by sea water. When galvanized metal is welded, the heat of the torch or of the arc boils off some of the zinc, which rises as zinc oxide smoke exactly as in the manufacture of brass.

SYMPTOMS

If a workman breathes zinc oxide fume or smoke in sufficient amounts and for a sufficient length of time, he may have an attack of metal-fume fever.[4] After a half hour or so he may note a substernal pain on taking a deep breath, and while this does not become serious an attempt at deep breathing may elicit an unproductive cough. Violent coughing or vomiting is rare. A metallic taste gradually may develop. After about four to six hours the body temperature begins to rise, usually following a premonitory chill. This chill may develop into a real malarial-like shake—hence the name "zinc shakes." The fever may go as high as 103 degrees Fahrenheit or even more—I have recorded a 103.5 degrees Fahrenheit on myself—and gradually will subside, until twelve hours later the body temperature is usually normal.

The leukocyte count will begin to rise within an hour or two following exposure—well before the body temperature rises—and will remain above normal for some hours after the temperature has subsided. Differential counts show that the rise in white cells is due to increased polymorphonuclears. If a second zinc oxide inhalation is taken when the temperature has returned to normal but with the leukocytosis present, there is apt to be no reaction. Apparently, the leukocytosis offers some measure of protection. At any rate, attacks of metal-fume fever on two successive days are rare, and men usually say they get it most easily after a lay-off. We had no difficulty in confirming these general facts by breathing zinc oxide ourselves.[5]

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† A Maritime contract yard at Portland, Oregon.

Another point to be stressed is that the effects are not cumulative. Animals subjected to heavy concentrations eliminate the zinc oxide rapidly—it is all gone in a day or so. There is no storage in any part of the body, nor could we find in examinations of men who had been exposed daily to zinc oxide for as long as twenty years, that their health was affected in the slightest degree. Metal-fume fever apparently does not predispose to tuberculosis or any other respiratory disease.

STEEL-PLATE WELDING

In welding steel plates, iron is boiled off by the arc or by the gas torch and burns to ferric oxide, Fe_2O_3, which rises as smoke or fume of a rusty appearance. Deposits of the fume on white cloth look like a rouge, for that is exactly what it is chemically. If men or animals breathe rouge powder, no systemic effect results. There is no metal-fume fever. However, animals exposed repeatedly do not eliminate ferric oxide the way they eliminate zinc oxide. The deposits seem to remain. Perhaps the lesser solubility of Fe_2O_3 in body fluids accounts for the iron noted by Enzer and Sander [6] in their autopsy report on a welder who died in an accident.

If one strikes an arc, a minute amount of NO_2 gas, nitrogen peroxide, is formed. The process is nitrogen fixation, and is one of the steps by which nitrogen of the air is converted commercially into nitric acid and nitrates. This gas, NO_2, is toxic and will produce fatal lung edema if breathed in excessive dosage. It is a lung irritant and can, likewise, irritate the trachea and bronchii. In commercial welding, as in ship construction, there is little or no danger of gas poisoning, but there are times when ventilation of welding jobs undoubtedly is inadequate. With poor ventilation of closed jobs the atmosphere is unpleasant and may cause coughing. We know this should not be, and we admit that fume and smoke concentrations sufficient to reduce visibility occasionally occur, but the evidence from our yards all over the country is that these effects, such as cough, are transitory. Gradually we are improving ventilation and are supplying adequate masks or respirators, to be worn beneath the welding helmets when ventilation is impracticable.

ELECTRIC WELDING

Electric welding first used bare rods or bare electrodes. Now it is usual to have rods coated with various inorganic substances and some organic binders. The purpose of the coatings is to create a reducing atmosphere immediately around the molten pool so that the weld will not be unduly oxidized. There is no magic in these rod coatings. The manufacturers have patents covering them, but their chemical composition is known, and the gases and fumes which they give off are in no way mysterious.

LEAD POISONING

The priming coat of paint in our Maritime freighters contains, as pigment, red lead. It is common shipyard practice to paint out in the yard small parts and even some deck and hull plates before they are welded into place. This saves time. The risk of lead poisoning to the welders who must weld such painted metal into position is recognized. The heat of the welding arc boils off some of the lead and the welder breathes the lead fumes evolved. It is the rule to leave four inches or so along the edges unpainted and the painters go over this surface later. We have not yet assembled reliable figures on lead poisoning in our shipyards, but all evidence indicates that we have recognized the danger sufficiently soon to escape it by these simple preventive measures.

RE: STERILIZATION

It will surprise the medical profession to learn that we have had considerable unrest among both women and men welders because rumors had reached them to the effect that the welding arc gave off "x-rays which could cause sterility." It is our job to stop such gossip as it can easily assume serious proportions. We pointed out immediately that the medical profession was well aware of the sterilizing action of x-rays; that the machines which are used to cause sterility usually operated at 100,000 or 200,000 volts; that welding machines all operate at twenty to eighty volts and could not produce any x-rays at all.

EARLIER STUDIES

Doctor Menne and his colleagues evaluate as "piecemeal" (page 5) prior studies of the health risks in welding. In 1938, Enzer and Sanders [6] reported upon the lung changes in welders who had had abundant industrial experience. In 1940, Britton and Walsh [7] of Northwestern University Medical School reported upon the examination of 286 men who had welded more than five years.

In 1940, too, Harrold, McCord, and Meek [8] reported finally on extensive studies on animals and men exposed to welding fumes and gases. In 1942, Gardner [9] showed that animals with tubercular lesions are not further harmed by comparatively heavy exposures to welding fumes.

COMMENT

Careful appraisal and study of the work above mentioned leads to a definite conviction that it can in no sense be regarded as of the piecemeal variety, and we cannot conceive of its dismissal in such summary fashion by any reasonable and clear-thinking individual.

In 1927, Drinker, Thomson, and Finn [10] suggested figures of threshold concentrations of ZnO in workroom air so that ventilation requirements could be computed therefrom. In 1935,[11] these suggested standards of air purity were extended to include Fe_2O_3 from welding iron and steel as in shipbuilding, and the figures were modified further in 1941.[12] Doctor Menne's report quotes these figures and accepts them.

There has been no attempt on the part of any of these investigators cited to belittle the health risks of welding. In fact, all of us have been accused by those interested in the practical aspects of welding as having stirred up unwarranted apprehension.

No useful purpose will be served by detailing the technical errors, especially in engineering, in the report of Doctor Menne's committee. We do not question the authors' good faith or good intentions. We agree with most of their eleven final recommendations, for many had been adopted last December in our Health and Safety Standards. We disagree with others. We would welcome improvements in goggles, helmets, air masks, or anything of the sort, but we cannot and will not recommend the general use in our yards of any protective equipment which has not been tested and approved by a reliable agency, such as the Bureau of Mines or Bureau of Standards.

STAFF OF THE MARITIME COMMISSION AND THE NAVY

The Maritime Commission and the Navy set up last December [13] a permanent staff of Safety and Health consultants for all of the contract yards in the country. Our physicians, industrial hygienists, and engineers know thoroughly what conditions are like in double bottoms, deep tanks, and refrigerator rooms. We go wherever the men go or are expected to go. We examine and take samples of the air in the course of our inspections. We attempt to anticipate and to prevent accidents of all kinds. We check constantly on the ventilation equipment, goggles, safety shoes, and guards of all sorts around machinery in every yard. We check in detail on the medical and first-aid facilities and general procedures in all yards. Our men are available at all times for consultations with management or with labor.

IN CONCLUSION

We note Doctor Menne's complaint that education of the men in the risks of welding and in the proper use of their protective equipment is not always good. We quite agree, and if his committee can help us improve the teaching in our apprentice schools and training courses we would welcome their aid.

The climax of the report and its chief objective is contained in the final recommendations for the adoption of an occupational disease law in Oregon. Since the recommendation was made, such action has been taken by the State. As representatives of the Federal Government we must accept State rules and State laws as we find them, and since this is exclusively a State matter, we have carefully avoided any comment on that section of the report.

c/o U. S. Maritime Commission, Washington, D. C.

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MEDICAL SERVICE IN THE U.S.S.R. ARMY

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San Francisco

THE most recent offensive undertaken by the Soviets has found medical science advanced to the point where it is able to cope with the needs of front and rear alike. Russia has been able to hold her losses of the wounded to less than 1½ per cent. This remarkable fact helps to explain the phenomenal strength and stability of her forces, for into her front lines returns a constant stream of seasoned veterans already baptized in the fire of bloody war and now recovered sufficiently to be a vital force in the conflict.

We can gain some understanding of the scope of the odds which have been surmounted when we realize that all the valuable equipment of institutions in cities which fell into enemy hands had to be previously removed. My own Alma Mater, Kharkov Medical Institute, I am thankful to say, is now operating in safety in the remote rear in the city of Chkalov.

While relocations such as this, which are of a magnitude to strain the resourcefulness of the most ingenious, have been carried out, the vital business of caring for the sick and wounded has had to increase rather than diminish in intensity and extent. Up to the present time, the Russians have trained 200,000 physicians as well as 600,000 male nurses to render service under fire. A dramatic illustration of the use of doctors is seen in the employment by the Soviet Army of an unusually large number of Para-doctors (doctors attached to the Parachute Corps). These men have been utilized both at the front and among the guerrilla fighters. They have even managed to organize hospitals in concealed places.

RECENT DISCOVERIES

From experiences at the front, in base hospitals and medical institutes of the Soviets has come a host of new and significant discoveries. Most of them are not only useful in the urgency of the moment, but are signposts to developments of even greater utility in the not too distant future.

The results which the medical profession has brought to light in its hot pursuit of new discoveries and ideas cover a wide range of material. We can gain an idea of these developments by a brief survey of some of these recent discoveries.

While studying changes that take place in frozen milk, one young scientist transferred his findings to human blood with the hope of learning how best to preserve it. This remarkable research won Stalin's Prize for him. It has also been brought to my attention that the Russians are doing pioneer work in utilizing the red blood cells, usually a by-product in the preparation of plasma.

Another great discovery was made when Dr. Kudryashov, the head of the Biological Department of Moscow University, isolated in large quantities thrombin, which works like magic in checking bleeding, and which is now being used extensively.

Dr. Linniks and an engineer named Maltz, have discovered a new method for producing phosphorus; the physiologist Ezra Astratyan, has developed a new method for the treatment of shock, which is being used successfully on the field of battle; and a one-jaw splint, which permits a patient to masticate food, has been introduced by Dr. Kurlyandsky for the treatment of jaw fracture.

The extensive use of a powder streptocide, which is closely related to prontosil, in the treatment of wounds has been of great value in reducing gangrene from the 15 per cent to 70 per cent in the last war to a bare 1½ per cent in the present war. This powder streptocide delays the spread of infection for some hours, until the casualty can be brought to the operating table.

Other major Russian developments in the treatment of the wounded include balsamic bandages, introduced by Dr. Vishnevsky and his son, and now widely used in all field hospitals. A new compound, related in function to vitamin K, has been made known recently; and the use of the peritonea of animals as living bandages for gaping wounds has been introduced to facilitate the healing of injuries. Surgeons are now dealing so efficiently with even the most disabling wounds, such as those caused by blast, crush injuries, flesh burns, compression injuries accompanied by internal injuries, that there is complete recovery in most cases.

Dr. Priorov's thesis on amputation and artificial limbs has earned him the title of professor. Dr. Kapterev, who started for the far North after the outbreak of the war, has been doing some highly interesting experiments on revivifying simple organisms which have remained frozen in anabiosis for over 3,000 years.

The Soviet medical profession, realizing that, in the past, infection and disease caused more deaths and disabled more soldiers than direct war casualties, labors constantly to keep the Army and the rear free from epidemics.

In this manner, and through the many ways merely touched upon in this article, we see tangible evidence of the contributions of Soviet medicine to the heroic struggle of Russia in its attempt to accomplish the final destruction of Hitlerism—that threat to civilization.

After concluding this discussion of Soviet medicine, I cannot help but recall the enormous dividend being paid humanity at the present time for the attention given to Russian children during the early days of the Revolution. At that time, the attention of the American Relief Association was focused on children's institutions. As a representative of a certain hospital which was without the necessary dietetic products, drugs, linen, bedding, etc., I had first-hand evidence of the effect of such generosity on the well-being of the Russian children. These same children, who have become the main fighting force of the Soviet Army, are now defending their Fatherland, and at the same time returning their debt to liberty-loving people a thousandfold.

450 Sutter Building.

NERVES OF THE ARM: SOME OF THEIR AFFECTIONS; THEIR DIAGNOSIS*

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San Francisco

NEURITIS OF THE BRACHIAL PLEXUS

FOLLOWING the later course, or in convalescence of general infections, an isolated neuritis of the whole or of a part of the brachial plexus may occur. This is usually unilateral. Its severity may vary considerably. This neuritis may be brought about by a great variety of infections, the etiology of which often is obscure. The neuritis, frequently diagnosed as brachialgia, is analogous to the postinfectious neuritis of the sciatic nerve. The upper part of the plexus is predominantly affected. The clinical picture in this case is that of the so-called Erb-Duchenne paralysis, involving the muscles supplied by C_5 and C_6: deltoid, supra- and infraspinatus, biceps, and brachialis internus. Such a paralysis, mostly motor, may occur in a completely isolated form after serum injections, especially after antitetanus injections.

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* From the Department of Neurology, Division of Medicine, University of California Medical School, San Francisco.

Read before the Section on Neuro-Psychiatry at the seventy-first annual session of the California Medical Association, Del Monte, May 3-6, 1942.

For convenience in presentation, the affections of nerves of the arm will be considered under their respective headings.

TRAUMATIC NEURITIS OF THE BRACHIAL PLEXUS

After severe, blunt, nonpenetrating injuries to the shoulder, such as a blow, fall, severe traction of the arm, the brachial plexus, though not directly injured, may suffer severe damage, may even be torn apart, and a complete motor and sensory paralysis of the arm may result. For the diagnosis of this condition, it might be helpful to remember that the sensibility of the skin on the upper inner side of the upper arm is usually preserved.

STRETCH NEURITIS OF THE BRACHIAL PLEXUS

After sudden, brisk overstretching of the arm, as in a violent movement of the elevated arm backward and outward, *i. e.,* throwing of a hand grenade, playing tennis, etc., long-standing, stubborn and painful paraesthesias in the arm and hand may develop. The quickness and sharpness of the movement is here more damaging than the range of stretching. Outspoken neuritic signs are absent, yet vasomotor-trophic changes may occur. Some constitutional disposition may play a rôle. It is justifiable to assume that we have to do here with a mild interstitial neuritis, or a perineuritis.

SCALENUS ANTICUS SYNDROME

In general practice the scalenus anticus syndrome—the so-called Naffziger syndrome—is frequently found. Its outspoken features are painful phenomena in the arm due to mechanical irritation of the brachial plexus as it passes over the first rib between the scalenus muscles. Operation—sectioning of the scalenus anticus muscle—brings prompt relief, and produces splendid permanent results. It is most essential, however, to select the proper cases for operation, since the causes of arm pain are extremely diversified. The question that arises always is: what is the cardinal, the obligatory sign of this syndrome? The answer is: tenderness to pressure over the lower end of the scalenus anticus muscle at its attachment to the first rib. This tender point is directly above the clavicle, lateral to the clavicular attachment of the sternomastoid muscle. This unilateral tenderness may be the only objective finding in this syndrome, and is usually very outspoken. So outspoken, indeed, that one should hesitate to diagnose the syndrome with certainty if this sign is not present.

BRACHIALGIA STATICA PARAESTHETICA

Not uncommonly, middle-aged people complain of paraesthesias, numbness or pain in the arm during sleep. These signs occur especially in ulnar distribution, and may affect, not the arm on which the patient lies, but the other arm. It is not easy to explain the exact mechanism of this syndrome, but certainly it is due to pressure on the immobilized nerves near the first rib. Constitutional anomaly in the course of the brachial plexus may play a rôle. The last word on this subject has not yet been spoken, but one can say with some degree of certainty that it is *not* a scalenus anticus syndrome, *not* a cervical rib, *not* a spondylarthritis, and it must be sharply differentiated from these conditions. It is a benign, nonprogressive condition, has a self-limited course, and is a definite clinical entity. Exercises to lift the elevators of the shoulders, diathermy, etc., of the plexus are often beneficial.

CERVICAL SPONDYLARTHRITIS

In all the above-mentioned conditions affecting the arm nerves, x-rays of the cervical spine are taken routinely. Usually a cervical spondylarthritis of more or less advanced degree is found in adults. We are *all* too easily led into making this cervical spondylarthritis responsible for every possible sign and symptom on the part of the arm nerves. For many years, in common with others, I, too, made this error. After having persistently treated a patient for spondylarthritis, I often found that he suffered from some other condition. The importance of spondylarthritis has been generally overestimated. Every adult has a spondylarthritis of some degree, but usually it does not produce any signs or symptoms of the arm nerves. X-rays of the adult cervical spine commonly present an unexpected picture of spondylarthritic changes, even though they represent only the normal wear and tear on the vertebrae. However, these x-ray findings are clinically, neurologicly insignificant. Occasionally, we may even see a dislocation or collapse of the vertebrae without neurologic signs. It is certainly true that compression of the nerves by an extreme cervical spondylarthritis, especially of a localized nature, occurs; but this must be regarded as very rare, and there must be special and compelling reasons to assume a connection between cervical spondylarthritis and arm nerve involvement. In any event, if a patient has a neurologic condition of his arm, together with a cervical spondylarthritis demonstrable by x-ray, it does not necessarily mean that this cervical spondylarthritis is at the root of his complaint.

NEURITIS OF THE SENSORY NERVES OF THE ARM

The sensory nerves of the arm—those supplying the skin exclusively—may be affected singly or in combination with other sensory nerves of the body. Such a sensory neuritis leads to numbness, paraesthesias, and eventually to pain in the area supplied by the nerve. The leading objective sign is pain appearing on stretching of the diseased nerve. On the arm, the nervus cutaneous antebrachii medialis may be affected, with resultant hypaesthesia on the inner side of the forearm. This may occur after general infections of any kind and is a harmless condition. More commonly affected is the ramus superficialis nervi radialis (cheiralgia paraesthetica). A concomitant affection of some other distant sensory nerve is not unusual. General infection or mechanical conditions, such as pressure of a tight strap of a wrist watch, may be the cause.

Test for Ulnar Palsy.—The most dependable test for ulnar palsy is the "newspaper sign" of Froment. Here a patient, holding a newspaper between his thumb and index finger, flexes the distal phalanx of the thumb in order to hold the paper more tightly. This is due to the weakness of the adductor of the thumb innervated by the ulnar nerve, and to the tendency of the patient to substitute this muscle by the intact flexor of the thumb innervated by the median nerve.

Thus, if this sign is positive it indicates not only that the ulnar nerve is damaged, but that the median nerve is intact. A further sign of ulnar palsy is the tendency of the patient to keep his little finger abducted. This is easy to understand: the abduction and adduction of the little finger is a function of the ulnar nerve, but the abduction is also performed by the musculus extensor digiti minimi, innervated by the radial nerve. If the ulnar nerve is damaged, and the radial intact, the action of this extensor muscle is unopposed, and abduction position of the little finger results. The tendency, then, is for the little finger to assume the position of abduction. This sign may be the very first and a very late manifestation of ulnar palsy.

Test for Median Nerve Palsy.—To reveal a median nerve palsy, we usually examine the opposition function of the thumb. But it is difficult to distinguish real opposition consisting of rotation of the thumb around its longitudinal axis, from the so-called "pseudo opposition" consisting of adduction of the thumb, performed by the ulnar nerve, and flexion by the long flexor innervated by the median nerve which is intact in lesions of this nerve at the wrist. Further, it must be taken into consideration that the thenar muscles which participate in the opposition, usually innervated by the median nerve, may be—to a varying degree—innervated by the ulnar nerve. It is, therefore, better to rely on the abduction of the thumb as an indicator of the function of the median nerve, since the abduction is an exclusive function of this nerve. On this is based the following test: the patient brings his inner fingertips together in a roof-like position at such an angle that the tips of the thumbs maximally abducted at right angles to the palms can touch each other. If median palsy is present, the tip of the thumb on the affected side is horizontally higher, due to deficient abduction.

PARTIAL THENAR ATROPHY

In speaking of median nerve palsy, it is worth while to mention that a median nerve neuritis should be distinguished from another condition called "partial thenar atrophy," that constitutes a definite clinical entity. In partial thenar atrophy we have an atrophy of the muscles located on the outer, radial side of the thenar: of the musculus opponens pollicis and of the musculus abductor pollicis brevis only. The affection may be unilateral or bilateral. The development of the atrophy is extremely slow. There are no objective sensory changes. It is apparently a chronic degeneration of these phylogenetically young muscles, and not a neurogenic affection.

University of California Medical Center.

MEDICAL EPONYM

Negri Bodies

The results of the studies made by Adelchi Negri (1876-1912) as an assistant in Golgi's pathology laboratory at Pavia were first presented before the Società Medico-Chirurgica at Pavia, March 27, 1903. "Beitrag zum Studium der Aetiologie der Tollwuth [A Contribution to the Study of the Etiology of Rabies]" appeared in *Zeitschrift für Hygiene und Infectionskrankheiten* (43:507-528, 1903). A portion of the translation follows:

"The phenomenon to which I wish chiefly to direct attention is first the occurrence of a peculiar microörganism in the nervous system of rabid animals; everything leads us to believe that this is to be considered a protozoön. . . . Almost always, the favorite site for the microörganism is the Ammon's horn—always if the infection is subdural. In this region, especially in the larger nerve cells, the parasites are present in large numbers."

In a paper, "The Etiology of Rabies: The diagnosis of rabies on the basis of new discoveries," which was read before the Società Medico-Chirurgica at Pavia, July 14, 1903, and appeared in the above journal (44:519-540, 1903) under the title, "Zur Aetiologie der Tollwuth: Die Diagnose der Tolwuth auf Grund der neuen Befunde," Negri made the following statement:

"On the basis of my studies, I have concluded that this microörganism, which is found solely in the nerve cells of the rabid animals, is the specific exciting cause of rabies."—R. W. B., in *New England Journal of Medicine*, Vol. 226, No. 13.

MEDICAL EPONYM

Schüller-Christian's Disease

Professor Artur Schüller (b. 1874), of Vienna, wrote a paper, "Ueber eigenartige Schädeldefekte im Jugendalter [Peculiar Skull Defects in Children]" which was published in *Fortschritte auf dem Gebiete der Röntgenstrahlen* (23:12-18, 1915). He described three cases, and a translation of his conclusion is as follows:

"Each of these briefly outlined cases represents a noteworthy and extraordinarily uncommon condition. Common to all three is the fact that there were extensive defects in the skull that developed without pain and without any cerebral symptoms of any sort—practically without symptoms of any kind. Neither could there be discovered in these cases any of the recognized causes for such defects in the skull. Of interest, too, is the presence of a hypophyseal symptom complex in two of our cases, namely, dystrophia adiposogenitalis in the first, and diabetes insipidus in the second. Finally, the relative rapid disappearance of the defects, which was clearly perceptible by x-ray, constituted a noteworthy feature of the second and third cases. We suggest the name "geographical skull" [*Landkarten-schädel*] as a suitable term for the peculiar appearance of the x-ray defects that we have described."

Dr. Henry A. Christian (b. 1876), Hersey Professor of the Theory and Practice of Physic, Harvard Medical School, described "Defects in Membranous Bones, Exopthalmos and Diabetes Insipidus: An unusual syndrome of dyspituitarism" in the *Medical Clinics of North America* (3:849-871, 1920). After presenting a case and referring to those described by Schüller, he concludes:

"A case is presented where, in a girl of five, there occurred the symptom-complex of very extensive defects in the skull bones, exophthalmos and diabetes insipidus. Only two other cases of this condition could be found in the literature. Diabetes insipidus suggests that the symptom-complex is due to a disturbance of pituitary function. Both of the other two reported cases showed evidence of disturbed pituitary function."—R.W.B., in *New England Journal of Medicine.*

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* * *

FOREWORD: AN EXPRESSION OF APPRECIATION

The California Tuberculosis Associations are deeply appreciative of the courtesy extended by the California Medical Association in making it possible to present the papers read before the 1943 annual meeting of the California Tuberculosis Association and the California Trudeau Society. It is hoped that this presentation will be of interest to general practitioners.

The California Tuberculosis Associations are anxious to continue the close and pleasant association which they have always had with the medical profession of the State, to the end that all our communities may approach the ideal level of community health.

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ORIGINAL ARTICLES

Scientific and General

THE TUBERCULOSIS ASSOCIATION'S PLACE IN THE CALIFORNIA HEALTH PROGRAM*

Wilton L. Halverson, M. D.
Los Angeles

Too much credit cannot be given our tuberculosis associations for the part they have played in the advancement of the public health program throughout California. The first organization for the control of tuberculosis in this State was formed in 1902, two years before that of the National Tuberculosis Association. The original California society was called the Southern California Anti-Tuberculosis League. In 1903, the tuberculosis committee of the California Medical Association was established. These two organizations operated largely in Southern California and in San Francisco. This activity in tuberculosis control in 1903 is of interest because the first steps to organize the California State Board of Health upon a modern plan were taken in 1905, when the Bureau of Vital Statistics and the Hygienic Laboratory were established.

The activities of the California Tuberculosis Association eventually led to the organization of the State Bureau of Tuberculosis in 1915.[†] (See historical footnote in opposite column.)

In the intervening years, hundreds of influential laymen, practicing doctors of medicine, and public health workers, bound together by the Association, contributed vastly to the dissemination of information relative to tuberculosis and the ways in which the disease may spread. Since those pioneer days many activities that were considered essential in the prevention and control of the disease have been adopted or discarded, but to a great degree the basic factors in the spread of the disease are still operative, and some which seemed to have been eliminated are returning to menace the health and welfare of our people.

CALIFORNIA'S HEALTH PROBLEMS OF TODAY

The California health problem of today is not a single issue; it is composed of many problems, most of which are associated in one way or another with the devastating world-wide conflict in which we are engaged. Among them are overcrowding, particularly in the vicinity of our war industrial plants; difficulty, not alone in the control of food and food sanitation, but primarily in obtaining essential foods for all people; difficulty in providing full and complete protection for public water supplies; inadequate control of sewage disposal in many parts of the State because of the difficulty of securing essential materials; shortage of drugs and various

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[*] From the California State Department of Public Health. Read before the California Tuberculosis Association and the California Trudeau Society, Fresno, April 7, 1943.

[†] Editor's Note.—To amplify somewhat, it may be permissible to add some historical data:

At a meeting of the Southern California Medical Society, Francis M. Pottenger, M. D., of Monrovia proposed the formation of an organization to combat tuberculosis, and the California Anti-Tuberculosis League came into being in May, 1902, with Doctor Pottenger as president and the late Charles C. Browning, M. D., as vice-president.

This society was the seventh anti-tuberculosis society to be formed in the United States and preceded the organization of the National Tuberculosis Association, which in its beginning had the name National Society for the Study and Prevention of Tuberculosis.

Conforming to the new name of the national organization, the Southern California Anti-Tuberculosis Society changed its name to become the Southern California Society for the Study and Prevention of Tuberculosis. In like manner the local Los Angeles Anti-Tuberculosis Society changed its name.

It is of interest to know that the Los Angeles Society for the Study and Prevention of Tuberculosis at a time when Dr. George H. Kress was its secretary brought out a Christmas Seal tuberculosis stamp in the same year as did the National Tuberculosis Association. The Los Angeles stamp was illustrated by the seal of the city of Los Angeles, and a reproduction appeared in the "Bulletin of the California Society for the Study and Prevention of Tuberculosis," a bimonthly publication, of which Doctor Kress was editor.

The movement for education concerning tuberculosis spread into other communities more, however, in the southern section of California than in the northern division. In 1903 Dr. N. K. Foster of Oakland became Director of the California State Board of Public Health, and in coöperation with the late Dr. C. C. Browning of San Bernardino submitted statutes to the California Legislature asking for an appropriation to carry on official educational work. In 1905 and again in 1907 the State Board of Public Health was able to secure an appropriation of $1,000. The Southern Pacific Railroad coöperated in 1909 by donating the use of a coach containing a traveling public health exhibit in which tuberculosis was emphasized. Free transportation was given to this coach as it was carried about the State, and much basic educational propaganda was carried on in this wise.

Dr. N. K. Foster was succeeded by Dr. William F. Snow as Director of the California State Board of Public Health. Doctor Snow later gave up his position to assume the directorship of the American Social Hygiene Association in New York, in which position he is still active. In 1911 Doctor Snow was successful in securing an appropriation of $5,000 to provide for a study of tuberculosis by a State Tuberculosis Commission composed of an Executive Committee consisting of five members, and an Advisory Committee of fifty citizens. The Executive Committee which was appointed consisted of Dr. George H. Kress, Los Angeles, Chairman; Dr. C. C. Browning, Monrovia; Miss Katherine C. Felton, San Francisco; Mr. A. Bonnheim, Sacramento; and Dr. R. S. Broderick, Oakland.

The Executive Committee carried on its studies with the assistance of Mr. Guy P. Jones, who was loaned by the California State Board of Public Health as clerk, and who is still an employee of the California State Board of Public Health.

The report which was submitted by the Executive Committee of the State Tuberculosis Commission in 1913 suggested that two measures of importance be adopted:

(a) That a Bureau of Tuberculosis be established, same to be under the jurisdiction of the California State Board of Public Health; and

(b) That a recommendation be made to the State that adequate funds be appropriated by the Legislature whereby every county of California which would establish tuberculosis wards or pavilions that would conform to standards laid down by the State Bureau of Tuberculosis should be given a subsidy of $3 per week per patient. The Commission's Executive Committee also emphasized the fact that tuberculosis was a community problem and registered its opposition to a State sanatorium or sanatoria. The adoption of these statutes had much to do with the progress recorded in the years that followed.

The first chief of the Bureau of Tuberculosis was Miss Edith Tate, who at the time of her appointment was the secretary of the Los Angeles Society for the Study and Prevention of Tuberculosis.

The history of the tuberculosis work in California, with particular reference to the development of county sanatoria, revolves thereafter in large degree around the official activities of the Tuberculosis Bureau of the State Board of Public Health.

During all this time, however, the California Tuberculosis Association, in conjunction with its local county, city, and district units, worked in close coöperation with the State Bureau of Tuberculosis. The funds for these organizations were raised largely through the sale of the Christmas seals, which in recent years, because of the splendid organization setup, have brought to the societies participating, funds that have permitted great expansion in the educational and other work. It is much to the credit of the Tuberculosis Associations which came into existence so early that California, in less than half a century, was able to greatly reduce the incidence of tuberculosis morbidity and mortality in the State.

G. H. K.

medical supplies, making difficult the treatment of communicable diseases; the presence of rapidly fatal diseases, such as epidemic meningitis and others that are less common during normal times. We have the virus keratoconjunctivitis, which occurs in shipyard workers, together with other problems associated with the health of workers in our war industries. We have the continual threat of plague and typhus fever, and now there comes the potential menace of malignant strains of malaria and other tropical diseases brought to us by soldiers returning from the tropical and subtropical areas.

These war-associated conditions tend to obscure the more basic causes of morbidity and mortality which are constantly with us, some of which have been favorably influenced by control activities while others are untilled fields waiting for the plow and harrow of research and the seed drill of health education.

OVERCROWDING

Overcrowding in our war industrial areas is critical. At the same time there are a few cities where vacancies run as high as 10 per cent. However, the present practice of opening factories in nonfactory towns is apt to increase our housing problem in the towns which have so far escaped.

Health department inspectors have found improvised dormitories with bunks crudely constructed, one above another, not more than 18 inches to 24 inches apart. The passageways between these bunks were so narrow that it was almost impossible to walk between them. Court proceedings were sometimes necessary to abate such conditions. One defendant, through his lawyer, argued that the patriotic motive of providing space for war workers was the only reason for the condition, and inferred that the health inspector in bringing the action was working for the enemy.

Also, indecent living conditions are a direct cause of absenteeism on the part of industrial workers. If after a few days the worker's wife cannot find a suitable place to live, the worker will take time off to assist in the search, and if available housing in the community is below the standard to which he is accustomed he is likely to move on to another community. This is expensive to industry, to the community, and to the worker.

Losses of sanitary inspectors to the armed forces and to war industries have so depleted the staffs of health departments that adequate supervision is available in only a few areas.

In most sections of California it would be healthier to provide tent cities, with a certified water supply, than to allow the present overcrowded conditions in certain trailer camps, dwellings, and rooming houses to continue.

FOOD

Recently, by Presidential order, the nutrition section of the Office of Defense, Health and Welfare Services has been transferred to the Department of Agriculture, and now is under the direction of Food Czar Davis.

On the state and local levels, health organizations are the logical groups to take the leadership in the feeding program, and at the present time the local defense council forms the most natural channel through which to work. Health agencies, in planning the program, will soon study the work being done by every organization in the field and will use these organizations to their full capacity, giving generous credit for the work which is being done.

Careful surveys have shown that not more than 20 per cent of industrial workers, in representative plants, are securing adequate feeding. This is partially due to food shortages, but to a greater degree to the lack of knowledge or desire on the part of the individual to make proper food selections.

In Los Angeles County the industrial section of the joint nutrition committee of the City and County Defense Council has instituted a four-point program as follows:

1. The provision of a nutritious midshift meal for workers in industrial plants.

2. The provision of a lunch halfway between the midshift meal and the close of the work-day, consisting of a citrus drink and a fortified cookie.

3. Education of the worker in the choice of nutritious foods.

4. Education of the workers' wives in the selection and preparation of nutritious meals and lunches.

To activate this and other aspects of the educational program there is a great need for full-time workers to act as executive secretaries of nutrition committees.

INDUSTRIAL HYGIENE

The problem of industrial hygiene is bound up with our whole health program today. This becomes starkly apparent when we remember that, because of illness, production a year ago was decreased by the equivalent of 20 battleships, 20,000 war planes, 40,000 tanks, and millions of machine guns. A major part of illness in industrial workers is not industrial in nature.

At the Surgeon General's conference a week ago the Honorable Paul V. McNutt stated that by the end of 1943, 62.5 millions of men and women will be in the armed and labor forces. This is a major per cent of the able-bodied adults of our country, and the primary responsibility of health organizations and health workers is to maintain a level of health which will permit our workers to be at their posts of duty without interruption.

Our fighting forces have amply demonstrated that they are much more than the equal of our foes if they have the arms, ammunition and supplies necessary to fight a modern war. This is primarily a war of production and transportation, and we have not yet demonstrated that we can win it.

The motto of our fighting forces is, "The difficult we do immediately; the impossible takes a little longer." The time has come when we must see clearly that we on the home front, here in California, are an integral part of the fighting force and not an isolated group of more or less auxiliary adjuncts. This realization must cause us to re-double our efforts in the prevention and control of disease because of the direct effect upon our industrial workers.

For example, the development of tuberculosis in the wife or child of an industrial worker will almost surely result in intermittent absenteeism on the part of the worker; and the same can be said of all chronic and, to a lesser extent, acute diseases.

The portion of the industrial hygiene program directed specifically at industrial hazards was initiated in California by the State Health Department in 1937. Insufficient funds and personnel have been a serious barrier to proper development to keep pace with war industries. The larger plants have, on the whole, well-organized accident prevention programs, but relatively few have given proper attention to plant hygiene, sanitation and the control of toxic dusts, vapors and gases.

A recent movement initiated by the industrial hygiene division of the health department to organize health committees in each plant is meeting with marked interest, and many such committees are already doing excellent work.

A ROUNDED-OUT PROGRAM IS DESIRABLE

Preventive medicine is a multi-faceted program. Whereas a few decades ago tuberculosis, diphtheria, typhoid fever and other infectious diseases were leading causes of death, today they rank well down the list and are led by the so-called chronic degenerative group.

Information relative to the prevention and control of many of these conditions is slowly being accumulated, and in some instances the time has come when health agencies must actively promote control programs. The question that immediately confronts us is how this can best be done. Shall individual agencies devoted to each condition continue to be developed, or shall the only strong organization—the Tuberculosis Association—step to the forefront. Obviously there are conditions which favor both viewpoints.

All are agreed that in a democracy health education is the most important factor in the prevention of disease and the promotion of health. Laws may be passed requiring a simple procedure, such as smallpox vaccination, but no legislation can ever induce the individual to go to his physician for the early diagnosis of what may be early heart disease, cancer, or pneumonia.

The Tuberculosis Association has proved its mettle in the field of health education. It knows how. It has the confidence of the people of every community. It has the opportunity and responsibility to enter the general field of health promotion, the like of which has never before presented itself. Already tuberculosis associations have broadened their scope of activities, and several of our prominent local associations are known as tuberculosis and health associations. This step was taken after careful planning, and its extension would, I believe, be of great benefit to the health program of our State and to the Associations. The resources and facilities of tuberculosis associations are being advantageously used, for instance, in the heart disease control.

In spite of war conditions, it has been considered advisable to initiate a rheumatic heart disease control program. Shall this be carried out by the Heart Association, or shall there be a combination of Heart Association and the Tuberculosis Association, giving the advantage of the experience and resources of both organizations? It seems to me that the answer is clear-cut, for by it both programs can, with proper guidance and planning, be strengthened.

The present emergency also presents an excellent opportunity for the Tuberculosis Association to step out into the field of promotion of the general health program. There is an interest today in health on the part of all segments of society which is placing the spotlight on the medical profession, and on voluntary and official health agencies. The U. S. Public Health Service and the Children's Bureau will, this coming fiscal year, make available to states approximately 50 million dollars to augment state health budgets. In many instances state health department budgets have likewise been increased. California's legislature has seen fit to augment the State Health Department budget by increasing the staffs of the maternal and child health and crippled children's bureaus, and by setting up staffs in public health nursing, industrial health and local health services.

I cite these increases to indicate the temper of the people of the State as expressed by their duly elected representatives. Likewise the Tuberculosis Seal sale has been the largest in history. These gains in resources have not come by chance.

The Tuberculosis Association's place in California's health program is to provide organization, leadership, funds, and special skills in the promotion of a total health program in every community where an association exists. As you go back home, reassess the health services available and do not feel satisfied until you, as a volunteer or a professional worker in a tuberculosis association, are certain that you are using your entire resources in the battle for proper feeding, housing, community sanitation, and for the control of disease.

WAR-TIME CREED FOR EVERY AMERICAN TODAY

Martin Treptow died at Chateau Thierry in 1918. In his diary was found the following statement:

"I will work . . . I will save . . . I will sacrifice . . . I will endure . . . I will fight cheerfully and do my utmost as if the whole struggle depended on me alone."

State Department of Public Health.
Phelan Building.

Placer Students X-Rayed.—During the month of January, tuberculin tests were given to the 170 junior and senior high school students at Roseville Joint Union High School, Placer County. Local physicians and nurses gave the tests. Positive reactors will be given x-rays. The program is financed by the Christmas Seal sale of the Placer County Tuberculosis Association.

THE CALIFORNIA APPROACH *

W. F. Higby
San Francisco

THE method of choice in tuberculosis case finding, as set forth by Plunket and others, and based on epidemiological experience, is to trace existing cases from the source—the reported case. This method is apparently sound, but can be effective only when there is adequate reporting, correlated public health nursing, adequate clinic facilities, a coöperative medical profession, sufficient sanatorium beds, and a well-organized health department.

There are few places in California where this condition exists. To obtain these facilities is the primary objective of a tuberculosis association. Many California counties are now approaching this goal. Given these facilities, there are those who say no supplementary methods need be used.

Unlike smallpox or typhoid, tuberculosis has an undetermined course. The presence of infection usually can be determined by the tuberculin test. Active disease in the lungs usually can be detected by the x-ray. The problem is to find the early case in the apparently healthy person before signs and symptoms appear.

WORK AMONG CALIFORNIA SCHOOL CHILDREN

Because school children and college students are widely accessible, these groups have been the first avenue of approach. The tuberculin testing and x-raying of positive reactors, and tracing back into the family to find the source, was begun in California with a systematic plan in 1932. With the exception of certain metropolitan areas, every school child in California has been offered this service during the past ten years, and hundreds of thousands of children have been tuberculin-tested. Tens of thousands have been x-rayed and tens of thousands of visits by nurses have been made to find the source of the infection.

This method, when first used in a given community, finds comparatively large numbers of cases. There are diminishing returns after the first few years. Generally health departments and school health departments are taking over this procedure, routinely testing the first grade, the freshmen and senior high school students. Many tuberculosis associations are still carrying on this work as an aid to the official agency.

Emphasis has been focused upon the preschool child because existence of infection is near the source and should be productive in finding cases if there is adequate follow-up and examination of all household contacts. The American Academy of Pediatrics has announced, as a policy, that tuberculin testing should be routine in pediatric practice.

CITIZEN GROUPS EXAMINED

In eighteen counties in California, routine examination of expectant mothers has become a part of the regular program. Almost universal consent is obtained in prenatal clinics for tuberculin testing and x-raying of these women. Many active cases have been found. There is statistical evidence that the rate of tuberculosis meningitis in these counties has been reduced. There is evidence that this procedure should be fostered in private obstetrical practice.

Revision of the law by the last legislature has given great impetus to the examination of school teachers and school personnel.

Many hospitals, as a matter of self-protection, are x-raying hospital employees and nurses. A small start has been made in certain areas on the routine x-raying of all clinic and hospital admissions in general hospitals and clinics.

Dublin has suggested that case finding among foreign groups, where the death rate from tuberculosis is high, is a most productive field for case finding. The Los Angeles City Association in its Negro population, and the San Francisco County Association in its Chinese population, have shown that there is much tuberculosis that can be found in these groups. Other associations have worked among the Filipinos, Mexican, Japanese, and other foreign racial groups.

Examination of employees of mercantile and industrial establishments, of food handlers, and members of labor unions began shortly after the organization of the California Tuberculosis Association in 1904. The examinations were made by history, physical signs, and clinical inspection. Many cases of tuberculosis were found, mostly in moderate or far-advanced stages.

About 1923, numerous California associations devoted considerable attention to the organization of medical departments in industry. This was stimulated by the operation of the Industrial Accident Law. Attention to this field was diverted by the Child Health Movement, in which local associations concentrated upon nutrition, summer camps, and preventoria. Budgets were almost exclusively used in forwarding these projects.

About 1930 attention became focused upon case finding, and tuberculin testing and x-raying of school populations. Recently there has been a national trend toward a return of emphasis to the adults.

FLUOROSCOPIC EXAMINATIONS

Mass surveys of adult population began several years ago especially with the fluoroscope. These activities have been intensified during the past three years. Nine county associations own and operate fluoroscopes and thousands of adults are examined each year.

During twenty weeks of 1942 the fluoroscope, given to the State Association by the 40 and 8 branches of the American Legion, was used by nine county associations. Approximately ten thousand persons were fluoroscoped during this period and nearly a thousand were referred for standard 14 by 17 films of the chest. The State fluoroscope is scheduled for constant use during 1943.

Alameda County was the pioneer in the use of the fluoroscope in mass surveys, beginning in 1935.

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* From the secretary's office, California Tuberculosis Association.

Read before the California Trudeau Society and the California Tuberculosis Association, Fresno, April 7, 1943, in the symposium on "War-Time Tuberculosis Case Finding."

San Francisco followed with this method of mass case finding. Scores of groups have been surveyed, and each year thousands of adults have been examined. Some of this work has been reported in the literature. Reports of the use of the fluoroscope by other county associations will be given at this meeting.

Coincident with the use of the fluoroscope in adult case finding there has been extensive use of 14 by 17 film in practically every county. In 1942 there were 2,529 x-ray films read from twenty-two rural counties by a panel of consultants for the State Association, and many others were read in local communities.

Trucks with portable 14 by 17 x-ray machines are operated by three county associations. Three county associations own and operate standard 14 by 17 x-ray equipment.

With the introduction of practical, portable, miniature x-ray film machines, the trend is toward the use of this apparatus for mass case finding in the general population.

In 1930, we set as our goal that every high school child in California should have an opportunity to have a tuberculin test, and, if positive, an x-ray by 1940. This has been accomplished. It is my conviction that it is not too ambitious a program to set as a new goal, that by 1950 every adult in California shall have had an opportunity for an x-ray of his chest, provided either by his private physician, by his tuberculosis association, or his county health department.

Two county associations, Orange and Santa Cruz, have purchased, and have in operation, 35 mm. Westinghouse photofluorographic units. The Sacramento County Association has ordered such a unit and has all priorities cleared. Four other associations have recommendations before their boards of directors to purchase such equipment, and Yolo and Solano have authorized purchase of the units.

Los Angeles County and Los Angeles City Associations have jointly purchased a General Electric portable photofluorographic stereo equipment mounted on a truck. This equipment has been delivered. The California Tuberculosis Association has also purchased identical equipment and delivery will probably be made in July. This latter equipment will be rented at operating cost to the local associations of the federation.

The Santa Clara Association has purchased similar equipment, which will be built in a trailer. The Pasadena Association has ordered a semi-portable 4 by 5 unit, which will be housed at their headquarters.

With all of this equipment in full operation, and with thousands of California men and women being x-rayed by the Army, Navy, Coast Guard, and United States Public Health Service, a real beginning will have been made in the conquest of tuberculosis. By September the California tuberculosis associations will be x-raying approximately 6,000 apparently well adults each week.

In facing mass case finding, as of 1943, it is well to note certain changes in the concept of tuberculosis concurrent with the perfection of the x-ray; the advance of surgical and clinical procedures, and with the development of full-time health departments.

When organized tuberculosis work was begun forty years ago, certain facts were apparent and measures to combat tuberculosis based on these facts were inaugurated. It was learned:

1. Tuberculosis was either consumption or tuberculosis of the bones or glands.
2. No methods were available to obtain early diagnosis.
3. In the majority of cases the diagnosis was the death warrant.
4. There was little effective treatment available except bed rest.
5. Ninety per cent of the population had been infected.

Methods to combat tuberculosis were established as follows:

1. The reporting of cases.
2. Establishment of clinics to diagnose tuberculosis by the crude methods then available.
3. Sanatoria beds, designed primarily for segregation of the sick from the well, were built.

MORE RECENT CONCEPTS

During the past decade new facts in relation to tuberculosis have been emerging which change our whole concept of the disease and of case finding. Let us compare these new concepts with those at the beginning of our campaign.

1. Early pulmonary tuberculosis may be recognized by x-ray examinations.
2. Most physicians can be trained to diagnose the disease in its early form.
3. In most cases, when discovered early, the course of the disease is short.
4. Active methods of treatment are available for all stages of disease.
5. Studies have shown that from one-half of one per cent to three per cent of the adult population has tuberculosis in a communicable form.
6. Tuberculosis of bovine origin has been virtually eliminated.

CONCLUSIONS

From the economic point of view it would seem logical that every citizen in California, regardless of economic status, should be entitled to a miniature x-ray film of his chest as a service for his purchase of Christmas Seals. As a protection of the medical profession, the procedure should be defined as the screening method to detect the cases of clinical tuberculosis in order that they may be removed from contact with their fellow citizens and placed under medical care.

The survey should not be considered a regular diagnostic procedure nor an assumption of responsibility in the field of medical treatment. In all cases when there is evidence of chest disease or abnormality, the patient should be referred to his own physician. The procedure should be considered only as a case finding procedure to search out among the general population those persons who need medical care and are not aware of it.

45 Second Street.

THE TUBERCULOSIS ASSOCIATION'S PLACE IN THE CALIFORNIA HEALTH PROGRAM *

MRS. HAROLD K. MOSLE
Ventura

WHAT is the objective of Public Health? There have been several definitions given, but this seems to cover the subject briefly: it is the prevention of unnecessary illness and premature death.

What is the objective of a Tuberculosis Association? Authorized forms of tuberculosis work state "that it is the education of the individual and community, to the end that tuberculosis may be prevented and adequate provision be made available for diagnosis, treatment, and rehabilitation."

In both of these objectives we have one outstanding similarity, the word "prevention." Therefore, we might say that, from a broad outlook of public health, both have the same purpose in mind, although this Association's work to this point has been specifically tuberculosis.

There has been a marked trend in the past two years toward generalization of our health education programs, and the effect of the war may speed up this trend. One cannot isolate our health education programs for tuberculosis from health education generally.

Briefly, we are now faced with the fact that California is rapidly becoming an industrial state. With this development, we will have the usual accompanying problems, such as overcrowded housing conditions, inadequate medical and hospital care, overtaxed sewerage systems, improper food sanitation, and inadequate garbage disposal, all elements requisite for a serious epidemic. We are now faced with the stern fact that many of our citizens will be returning from the Pacific and other war zones where they have existed under living conditions beyond our comprehension. With them will come contagious diseases hitherto unknown. California will bear the brunt of prevention of the dissemination of these diseases throughout the nation.

It is the opinion of the speaker that the Association can adopt a total health program and that serious consideration should be given to such a procedure immediately.

Some of our posters and literature can be generalized, and it may be that after years of concentration on tuberculosis education a curt, brief sentence here and there on that subject will make a sufficient impression. General health education can be given in all groups contacted for x-raying, such as food handlers, selective service and industrial plant rejectees, students, teachers, clinic and hospital admissions. The Association could provide assistance in increasing budgets of health departments, and encouraging students to become interested in public health careers, for hundreds of well-trained workers will be needed to face the old and new problems; assistance and leadership in solving medical problems for industry, providing health education for housing units and encouraging health surveys, that communities may be ever alert to their changing health conditions. Health libraries could be provided for schools, stressing the education of both the teacher and the pupil. These health libraries should be a growing institution, with new information added when available. Comprehensive, outstanding health books could be provided from Association libraries for use of the teachers and others. Some of our health films could be more general in their treatment of health subjects.

The past record of performance of the California Tuberculosis Association proves its value as a volunteer health organization for the prevention and cure of tuberculosis. No other volunteer health group is better equipped for mass application of the principles of public health.

In 1905, speaking at the first annual meeting of the National Tuberculosis Association, Doctor Trudeau said: "The first and greatest need is education; education of the people and, through them, the education of the State." Tuberculosis is not specifically mentioned in that statement, although we know that it was applied to that subject. Applying it to public health, it has the same truth and the same power as to a broader field of possibilities.

The postwar period will include rebuilding of the health of the peoples of the world. It will require strong healthy citizens. To the volunteer agency falls the task of pioneering, exploring and interpreting to the public the need of official agencies and supplementing the work of such agencies. All this we have done in the past as applied to tuberculosis. We are now in a position to accept the challenge to apply our knowledge and ability to perhaps the largest health problem we have ever faced.

Route 1, Santa Paula.

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* From the Ventura County Tuberculosis and Health Association.
Synopsis of a paper read before the California Trudeau Society and the California Tuberculosis Association, Fresno, April 7, 1943.

THE TUBERCULOSIS ASSOCIATION'S PLACE IN THE CALIFORNIA HEALTH PROGRAM *

HENRY A. RANDEL, M. D.
Fresno

I SHOULD like to express a somewhat different interpretation upon the matter under discussion. I admit that we are greatly influenced by conditions which confront us locally. These we see, whereas the situation as it exists in other parts of the State and nation we are made conscious of only by "what we read in the papers." Thus, as practicing physicians working under forced draft, we visualize our community still faced with a rather high tuberculosis incidence and mortality rate. We are told that we may easily expect these rates to rise as the result of conditions to which Doctor Halverson referred, namely, nutritional deficiencies, crowded housing conditions, etc. We are conscious of the fact that methods for the prevention and control of tuberculosis have changed since many of the busy practicing physicians received their training. The public, we feel, is still very much in the dark, with reference to some of the very elementary concepts of disease prevention.

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* From the Fresno County Medical Society.
Synopsis of a paper read before the California Trudeau Society and the California Tuberculosis Association, Fresno, April 7, 1943.

Consequently, it is our opinion that the time has not yet arrived whereby we can safely forget or even subjugate our intensive efforts as an association toward the eradication of "the white plague." The idea has been expressed here today in favor of the isolation and forceful quarantining of recalcitrant patients as a means of stopping one of the leaks. No sooner had the idea been voiced, however, than the feasibility of the proposal was challenged. Who is to decide the issue? Our Association, with its limited specialized activity, will be expected to lend its influence, one way or another. The public wants this, for it is they who contribute annually their pennies and dollars to us for one purpose alone, namely, to fight tuberculosis.

2607 Fresno Street.

COMBAT AND CONSUMPTION *

Lt. Comdr. Emil Bogen, M.C., U.S.N.R.
Portsmouth, Virginia

THE military significance of tuberculosis, the effect of the tubercle bacillus on the course of battles, campaigns, and wars, has received little attention. Biographical historians have commented on individual generals who were stricken, and survived or succumbed to the disease, and the historical changes that might have attended a different outcome, but acute diseases have been even more emphasized in this connection. Relatively few of the casualties among the armed forces during the actual conflict are ascribed to tuberculosis. Humanitarian feeling and economic motives, as well as recognition of cold military considerations, have generally been responsible for the measures which have been taken by the armed forces with regard to the disease.

TUBERCULOSIS AND THE SOLDIER

Nevertheless, in the development of total warfare to the prolonged process of attrition which is characterizing the present conflict, tuberculosis assumes an importance which may become decisive. The nearer a consumptive is to the front lines before he becomes incapacitated, the greater is the resultant loss to his country, not only from his own disability, but from the expenditure of material and effort required to bring him up the front line only to find him ineffective, the corresponding cost of his evacuation, and the strain on the limited medical and other facilities at the front. All of the expenditure of time, money and material, and especially of available facilities for training armed men, which is wasted on an individual who becomes incapacitated by tuberculosis before he can be utilized fully in battle detracts from the fighting chances of his country. The elimination of active consumptives, or the potential victims who are most apt to develop active disease, from the armed forces at the earliest possible time, before rather than after enlistment, therefore becomes a matter of practical military importance. There is a special danger for the armed forces in that the battlefields of this war are apt to occur in the very places where tuberculosis abounds. Philippines, Japan, Chile, Morocco, Greece, Italy, Spain, Finland, and Poland have been particularly affected, and soldiers there are exposed to massive infection from tuberculosis as well as to the machinations of the human enemies.

TUBERCULOSIS AND THE CIVILIAN: UNDER WAR-TIME CONDITIONS

Tuberculosis among the civilian population also is of military importance. The man-power reserves, from which future enlistments may be sought, are dependent to no small measure on the general levels of civilian vitality. Thus, the fact that, of the population of the United States today, less than one-fourth are too young to bear arms, or under 15 years of age, while at the time of the Spanish-American War, in 1900, more than one-third, or 40 per cent more of the population were of no military value for this reason, has a direct bearing on our military prowess. The high death rate among the Japanese, from tuberculosis and other causes, leaving her with a population nearly half of whom are under military age, may go far in winning the war for us.

The fact that tuberculosis strikes hardest at the ages of greatest military value, from 18 to 45, not only increases its potential danger to the armed forces, but also causes a great loss in man power for war industries, agriculture, and the many civilian activities essential to the continuance of the war economy. The lowered fertility of the tuberculous woman, the reluctance of the tuberculous man to assume the obligations of parenthood, mean further depletion of national reserves for future conflicts.

The severe drain on the economic and social, as well as the man-power resources of the country resulting from tuberculosis also constitutes a factor of importance in military logistics. Whether in an institution or at home, whether cared for by taxes, charitable organizations, relatives or friends, or his own accumulated savings and paid attendants, the patient with tuberculosis requires accommodations, materials, medical and other personal services, which are thereby made nonavailable for the armed services. Resources spent in caring for tuberculosis patients cannot be used for military purposes; the failure to isolate and care for patients with tuberculosis results in even more wasteful expenditures.

WHAT STEPS SHOULD BE TAKEN?

Consideration of the effect of tuberculosis on the conduct of the war, and of the effect of war

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* Read before the California Trudeau Society and the California Tuberculosis Association, Fresno, April 7, 1943, in the symposium, "War-Time Tuberculosis Case Finding: Summary and Conclusions."

The opinions and assertions contained herein are the private ones of the writer and are not to be used as official or reflecting the view of the Naval Department or the naval service at large.

on tuberculosis morbidity and mortality, is not merely an academic exercise. The prime importance of the most efficient and economical utilization of the resources at our command in order that we may win the war, first, and later the peace that is to follow the war, requires that we should understand the values involved.

The first immediate requirement is the detection of the tuberculous before they have entered the Services, and their removal if they are already enlisted, or commissioned, before they have wasted the facilities needed for their training and equipment, only to have them break down of the disease before they could be "expended." This has been extensively well done, but there are still loopholes; men slip by who should never have been accepted.

The obvious corollary of the above is the provision of facilities for the further diagnosis, treatment, and isolation of the active cases revealed by the Service examinations. This is being done less extensively, and only too often a lag occurs which may be disastrous. The rest treatment is insufficiently enforced in service and veteran hospitals; collapse therapy is unduly delayed and isolation is neglected. Voluntary agencies must try to get the Services to understand the need for these and provide aid in their accomplishment, as well as facilitate the transfer of the men from the acute general hospitals and receiving centers to special tuberculosis sanatoria.

TUBERCULOSIS AND WORLD WAR I

The rise in tuberculosis death rates in almost every country on the earth during the First World War was consistent and impressive. Although the influenza outbreak may have contributed somewhat to the peak of the rise, few seem to doubt that the rise was the result of the war itself. The natural inference has been widely accepted, therefore, that war in itself is inevitably accompanied by an increase in tuberculosis. Long before America entered the present war, Cassandra-like croakings predicted a corresponding rise in the rates here this time, and every straw has been pointed to as an indication that the rise was actually occurring. This idea influences our mental state and war-time civilian morale, and also determines the practical measures which we are to take in regard to the disease.

Throughout centuries of history marred with repeated wars of every description, meticulously recorded by hosts of avid observers, as Long has emphasized, it was not until the war of 1914-1918 that the association between tuberculosis and war was so strikingly revealed. Perhaps, as Long suggests, this may have been due to the heavy toll of the filth diseases in earlier wars, typhoid and typhus, plague and dysentery, carrying off so many that the increase in deaths from consumption was indiscernible.

Even during the First World War, the rises in the tuberculosis death rates were not synchronous in all countries, as emphasized by Faber, and showed variations in time and place independent of the declarations of war and the cessation of hostilities. Tuberculosis rose higher in conquered than in conquering countries, more with blockade than with invasion, and more with inflation and business booms than with depression and unemployment. Nevertheless, war in general tended to be associated with increased tuberculosis death rates in the countries actually involved.

INTERPRETATION OF TUBERCULOSIS MORTALITY RATES

Rise in war-time tuberculosis mortality rates by no means is synonymous with increase in the extent of the disease. In fact, the very death of the consumptive may tend to diminish the spread of the infection. Reports from workers in Europe and America during and immediately after the war indicate that the increase in the death rate from tuberculosis was due mainly to the increased lethality rate among those previously affected, rather than to an increase in the extent of the infection. To some extent the increased tuberculosis mortality rate may have reflected breakdown of arrested disease, but it seems unlikely that it was associated with a great increase in the infection rate among most populations.

An exception must be made for the African French troops and certain other instances where a people previously unexposed to the disease were suddenly placed in intimate contact with open cases of tuberculosis. Such instances undoubtedly exist and may be increased by war-time conditions, but seem to be of relatively minor importance in affecting the total situation.

The effects of war are not exerted equally upon all elements in the population. Influences affecting one group may be exactly reversed in regard to another. Thus, for example, troops in actual combat, whether on the ground, in tanks, in the air, or on or under the surface of the sea are subjected to congestion, strain (physical and mental), bad ventilation and hygienic and sanitary dangers, scanty and ill-balanced rations, and all kinds of physical trauma and exhaustion, which may well lead to breakdown from any disease latent within them. On the other hand, it is notorious that the armed forces of all countries, especially when not subjected to the exigencies of the actual front line, live on the "cream of the land," receive sanitary and medical protection, the most carefully planned and inspected diet, and every effort is made to preserve their health. There are, perhaps, hazards in the admixture of large groups of men for the first time in recruiting camps and pools awaiting distribution, and during maneuvers, etc., but they are, in general, under much healthier conditions than are their civilian confreres.

Again, military prisoners are subjected to greater danger of contracting or succumbing from tuberculosis than almost any other element of the population. Despite the admirable work of the Red Cross organizations, many prisoners are still, as throughout history, exposed to cramped congested quarters, unsanitary surroundings, inadequate diet, and all kinds of physical and psychic trauma. The increase in tuberculosis among prisoners is striking. Isolation from fellow prisoners who happen to carry open lesions is practically impossible. In the case of the Americans taken in the Pacific, as in those in North Africa, the hazard is increased by the high incidence of the disease among their captors and the local population who may be mixed with them in internment. A special project to demand chest x-ray and other protection of every prisoner whose liberty is recovered by exchange or reconquest might well be undertaken, first by private agencies, perhaps, but eventually by the armed forces themselves, to prevent the survivors of imprisonment or other hardships from becoming menaces to their own comrades.

Among the civilian population living in lands remote from the scene of actual combat, the dangers from tuberculosis are subject to their own control, in war time as in peace. The variations in the incidence of infection and disease in different age, sex, and other groups, and the variations in the factors affecting them should all be taken into consideration in considering preventive activities in such groups.

IN CONCLUSION

The midst of war is not the most satisfying time to prepare a long-range plan. But it presents opportunities which should not be overlooked. The immediate hazard now, during the war time, is that laxness and letdown may lead to an increase in tuberculous infection, and a rise in the incidence of the disease. Our first job, then, is to hold on to the gains that have been made, to lessen still more, to stop, wherever possible, the exposure to tuberculous infection, as well as to care, humanely and sanely, for those whose misfortune make it necessary to isolate them from their fellows.

In addition, the complete eradication of human tuberculosis, following the path of the bovine form, is now within sight in this country. America may well show the way to freedom from fear of the white plague. It is still a far cry to freeing the world from this enemy. But, county by county, country by country, continent by continent, the goal lies before us, and our opportunity as well as our duty looms clear.

Station Hospital.

WARTIME INDUSTRIAL EXPOSURES IN RELATION TO TUBERCULOSIS*

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IN the past, war has increased mortality due to tuberculosis, and the question is naturally raised: Will it happen again in this war in this country? Whether it does or not, certain situations which worry us as potential causes of increased tuberculosis are: food shortages; the employment in industry of young people, particularly women between 16 and 30 years of age; reemployment of arrested cases of tuberculosis; inadequate case-finding programs in industry; overcrowding; increased contacts; and overwork.

Of unusual interest is the possible contribution to this increased morbidity and mortality of the physical environment in industry—of toxic dusts, fumes, gases, and vapors. The problem justifies consideration due to the increased utilization of certain toxic materials as, for example, sand instead of shot for blasting, because metal must be diverted to the battlefield.

California industry is near the flood tide, having received to date orders for about $10,000,000,000 worth of war supplies. Employment in California manufacturing industries, exclusive of agriculture, is nearly two and three-quarter millions. The majority of these workers are protected by compensation laws, which naturally create a consciousness on the part of the worker and his physician as to the possible relationship between work and illness.

TUBERCULOSIS IN INDUSTRY

It was largely this consciousness on the part of workers generally which prompted the symposium on tuberculosis in industry, held at Saranac Lake, New York, in 1941, at which over thirty papers were presented, and the general conclusion reached that, aside from socio-economic factors, nutrition, silica, and the tubercle bacillus itself, it was not possible to incriminate categorically other factors as causative of the rising incidence of tuberculosis which accompanies advancing age. To this list, trauma should be added as capable of reactivating preëxisting latent tuberculosis. The rôle of dusts, fumes, gases, and vapors, with the single exception of silica, was considered to be negative. This conclusion, if justifiable by fact, may require on the part of physician and layman alike a considerable amount of *unthinking* in respect to tuberculosis. The voluminous statistical, clinical, and experimental evidence, which was brought out at the symposium and in other studies, and which has an important bearing on the subject of this paper, may be summarized as follows:

In order for tuberculosis to develop, there must be tubercle bacilli. They usually come from without; but old, dormant organisms within the lung can undoubtedly be reactivated. In order to favor the development of tuberculosis, foreign matter present in the lungs must have a *specific* action on lung tissue favorable to the growth and multiplication of the tubercle bacilli.

ACTION OF SILICA

Among dusts, silica is the outstanding example of a substance which does this. It creates with dead lung tissue some compound of silica that is particularly favorable to the growth of tubercle bacilli. As far as is known, no other substance produces such a compound. Injection of strong irritants, like mineral acids, croton oil, cantharidin, and turpentine, kills tissue, but does not provide a medium in which tubercle bacilli grow especially well.

The effect of silica is not due to its hardness. Finely divided carborundum dust having sharp edges, of a greater hardness than silica particles, does not produce the nodular reaction characteristic of silicosis.

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* From the State Department of Public Health, Berkeley. Read before the California Trudeau Society and the California Tuberculosis Association, Fresno, April 7, 1943.

Silica can cause practically every type of cellular response produced by the tubercle bacillus itself. It is, indeed, remarkable that a simple inorganic compound, such as silica, can set in motion a complicated series of cellular reactions comparable to those produced by a living organism. The nature of this action remains a mystery, but is believed to be due to undefined physicochemical properties of the surfaces of the silica particles. The effect is different from that of any other inorganic material that has been investigated.

ACTION OF OTHER DUSTS

Asbestos, on the other hand, is believed to have a mechanical rather than a physicochemical effect; and while a disabling fibrosis may result from exposure to asbestos, the fibrosis is different from the reaction due to silica. When experimental animals are exposed to finely ground asbestos, the mechanical effect of asbestos is destroyed and there is no lung fibrosis. If the action were physicochemical, the finely divided particles would accelerate the action.

Except for silica, the majority of dusts which make workmen uncomfortable and cloud the workshop are, in respect to tuberculosis, physiologically inert. Talc and other silicates may produce in the lungs various amounts of nondisabling fibrosis, but the formation of fibrous tissue is not enough in itself to predispose to tuberculosis. Fibrosis is characteristic of healing tuberculous lesions and is not characteristic of new tubercle formation.

The lungs must be considered not only as a repository for material inhaled, but as an avenue of absorption into the body. After absorption, specific systemic poisoning may result. Take lead, for example. Belknap denies that lead absorption or intoxication predisposes to or aggravates pulmonary tuberculosis. Finely divided oxides of lead, lead carbonates, chromates, and sulphates are quite soluble in body fluid, and when lead is inhaled in the form of these compounds, it readily passes through lung tissue, is absorbed into the blood stream, and produces its characteristic systemic poisoning. On the other hand, finely divided metallic lead may be held for a longer time in lung tissue and set up a local fibrosis, a mechanism which was used at one time to explain an apparently excessively high tuberculosis mortality rate among printers; but more recent statistical and clinical studies have denied increased tuberculosis morbidity or mortality among printers.

Arc welding, now so common in war industries, may serve to illustrate a unique type of local reaction in the lungs. In the heat of the welding arc the metals involved are converted to oxides, which enter the small air spaces of the lungs, where they presumably cause denaturization of the protein of the lung tissue. This changed protein causes a foreign protein reaction similar to the chills and fever which may result from subcutaneous injection of typhoid vaccine or other foreign protein. This reaction, known as metal fume fever, is a self-limiting illness. But a few arc welders, working in enclosed tanks, have developed a nontuberculous pseudonodulation due apparently to focal collections of fine iron particles. Confirmatory tests on animals indicate that arc-welding fumes do not prevent healing of a recent tuberculosis and do not reactivate an old experimental tuberculosis.

GASES AND VAPORS

Henderson and Haggard have classified environmental gases and vapors with the local and absorptive actions in mind. A modification of their classification, which is more convenient for our purpose, is as follows: (1) Simple asphyxiants, like nitrogen, that exclude oxygen from the lung. (2) Chemical asphyxiants, like carbon monoxide, which, after absorption, act upon the blood or tissues to prevent transportation or utilization of oxygen. (3) Irritants, like the fumes of nitrogen oxide, which injure the surface tissues of the respiratory tract. (4) Volative substances, like the hydrocarbons, which after absorption produce their specific pathological action.

From the standpoint of tuberculosis, our chief interest is in the irritant gases. Their action is explained by Henderson and Haggard, as follows:

> The selective action of the various irritants upon different parts of the respiratory tract is due primarily to the differences in the solubility of the gases. Thus, a gas which is readily soluble in water is taken out of the inspired air by contact with the first moist tissue which it reaches. As a consequence the upper respiratory tract bears the brunt of the action; the lungs are relatively little affected, since the concentration of the irritant which reaches them is greatly reduced by absorption in the upper passages. In the case of those gases which have a low solubility in water, the upper respiratory passages suffer little, for little is absorbed, and the main damage is done deep in the lungs. A gas of moderate solubility exerts its action more or less uniformly throughout the entire respiratory tract. Thus, the irritant gases are dangerous inversely as their solubility. The less soluble any one of them is, the more insidious it is.

Such damage to lung tissue may lead to edema and bronchopneumonia, but not to tuberculosis. At the Saranac symposium it was said: "The great majority of human beings exposed to various respiratory irritants in their occupations show no evidence of tuberculosis, and at least 5 per cent of them carry to their graves the scars of healed or partially healed tuberculosis."

On the effect of exposure to gases, our best source of information is the experience of the past World War. The report of the Surgeon General of the U. S. Army for 1919 showed that among 70,552 American soldiers who had been gassed, 173 cases of tuberculosis subsequently developed, a rate of 2.45 for 1,000. The corresponding rate for all enlisted personnel overseas was 3.50 in 1918 and 4.30 in 1919. In other words, there was less tuberculosis among the gassed than among the entire enlisted personnel. Experiments on gassing tuberculous rabbits bear this out.

Annual roentgenographic examination of considerable groups of men engaged by a plant in manufacture of chlorine, sulphodioxide, hydrofluoric acid, etc., showed no trace of reaction attributable to gas, and the incidence of tuberculosis was no greater in these men than in persons employed in other departments of the same plant. Latent apical disease in several men in the exposed group was not reactivated.

EFFECT OF OTHER FACTORS

The next question of interest is whether acute respiratory disease *per se,* as pneumonia, acquired off or on the job, affects the incidence of tuberculosis. The answer is probably negative. Lobar pneumonia, developing in the same lung or lobe involved by a chronic tuberculous process, rarely has any unfavorable influence upon the preëxisting tuberculous infection; the same has been noted in experimental animals. Some observers have even claimed that acute pneumonia in humans has promoted healing of the tuberculous focus.

In experimental guinea pigs, a preëxisting pneumonia usually prevents tubercle formation on exposing the animals to inhalation infection. Coal miners, who have a high mortality from acute respiratory disease, have a notoriously low mortality from tuberculosis. In six of eleven cement plants, where x-ray examinations of workers were made under supervision of the New York State Division of Industrial Hygiene, those groups reporting the highest incidence of bronchitis, epidemic influenza, nonepidemic influenza, and pneumonia, exhibited not a single case of active tuberculosis.

On the other hand, the pandemic of influenza of 1917 and 1918 was followed by an excessive number of new cases of tuberculosis, and it is believed that the extensive damage to the lung structure by the influenzal infection may have had a specific effect, predisposing to tuberculosis, although this was not borne out by the New York State study in cement plants.

Lastly, in the summation of environmental factors, temperature and humidity have no demonstrable effect on the incidence of pulmonary tuberculosis, according to statistical studies among laundry and textile workers exposed to high temperatures and high humidity. One explanation advanced is that the body's physiological response to temperature and humidity affects the upper respiratory tract, the hemopoietic system, body temperature, circulation, metabolism, skin, and rate of respiration, but does not specifically alter lung tissue.

A study of the effect of hard physical work in the hot environment of a steel plant showed no greater incidence of tuberculosis among employees than among applicants for work at the plant. The workers on light jobs managed their tuberculous infections better than those on hard and moderately hard work, but the difference was not enough to warrant a feeling of security with respect to clinically significant tuberculosis among workers on light jobs.

EXPERIENCE IN CALIFORNIA

The war has increased the exposure of California workers in particular to the fumes of the welding arc; to organic solvents used for painting or coating various surfaces, and for pickling or cleansing metal; to acids for electroplating; to metallic fumes and vapors in mining, refining, processing, or otherwise working with basic metals and alloys; to cutting oil; and to luminous paint containing radium. None of these exposures, so far as is known, predisposes to tuberculosis. Exposure to silica in foundries in concentrations above a maximum permissible limit is relatively infrequent due to the employment of wet methods and the use, for separating the metal from the mold, of parting compounds containing small amounts of silica.

In the reporting of cases of occupational disease in California during the past year, the small number of cases claiming an occupational origin for tuberculosis is striking. Among approximately 10,000 case reports, only twenty-five are for occupational tuberculosis, and of these not more than seventeen seem justified. Eleven of the seventeen workers were exposed to silica—foundrymen, grinders, sandblasters, quarry workers, and, singularly, a ranchman and a tractor operator exposed to the sand in the soil. Five other cases were in nurses or technicians exposed to the tubercle bacillus in the laboratory or hospital, and one worker claimed he was exposed to an infected worker. The eight cases classed as doubtfully occupational were among metal grinders, concrete mixers, butchers, and explosive-powder operators.

The evaluation of the environmental factor in relation to tuberculosis is assuming greater importance from day to day because of the employment of handicapped workers, notably arrested cases of tuberculosis. Should the rehabilitated tuberculous case be exposed to noxious fumes? Rules for employment of old tuberculous cases vary, but one set includes: No work on graveyard shift; no continuous walking or standing; no exposure to unusually dusty atmosphere, to oil spray or fumes, to temperature extremes or sudden changes of temperature; restricted weight lifting. If what has been said previously is true, many of these restrictions may be of doubtful value, although their enforcement provides a comfortable margin of safety.

Certainly, the available evidence indicates that needed control must be directed toward what is termed *personal,* rather than environmental hygiene. And under personal hygiene are included adequate case-finding surveys in industry. Unless war-time industry develops new silica-like substances, and becomes careless in their use and in the use of silica itself, an increased incidence of tuberculosis, should it occur, would undoubtedly be due to lack of measures fostering a healthy personal life rather than due to dusts, fumes, gases, and vapors in the working environment.

2002 Acton Street.

Babies can be infected with tuberculosis during the earliest days of life and such infection in certain cases tends to progress rapidly and often ends fatally. The diagnosis of tuberculosis meningitis or generalized tuberculosis in an infant or child should initiate an immediate and intensive search for the source of infection.
—A. S. Pope, M. D., *Jour. of Pediatrics*, March, 1942.

I have lived to a riper age than years can show. 'Tis deeds make old: these must thou number: with these was my life fulfilled, not with idle years.
—Ovid, *Consolatio ad Liviam*, 1. 448.

MICROPHOTOGRAPHIC EXAMINATIONS OF THE CHEST AT THE U. S. NAVAL TRAINING STATION, SAN DIEGO*

Comdr. Paul V. Greedy, M. C., U. S. N.
San Diego

THE method adopted by the Navy for these examinations is as follows: The recruit is placed in the usual postero-anterior position before a fluorescent screen, which is fixed at the end of a 38-inch ray-proof tunnel. At the opposite end of this tunnel a camera, containing a roll of 35 mm. film is attached. This film has an emulsion which is especially sensitive to the green light produced by the screen used. The final record obtained is a photograph of the fluorescent image produced on the screen when it is activated by x-rays. The film is read in strip form by passing it through a special viewer, which allows a magnification up to approximately three diameters. After interpretation the film is cut, put in individual envelopes carrying the identification of the original subject and sent to the Bureau of Medicine and Surgery in Washington for permanent filing.

Up to the time of my assignment to this duty I had had no experience with photofluorography. I was at first very skeptical of the value of this method of examination. When one is used to viewing radiographs of the chest on the standard 14 by 17 film, with its 238 square inches of radiographic shadows, and then is confronted with one square inch of shadows to take the place of his usual radiograph, his first reaction is doubt, if not outright prejudice. The previous habits of eye and mind are disturbed, and the resultant mental reaction is unfavorable.

AUTHOR'S EXPERIENCE

During my first six weeks of this new duty, I expended a large number of standard-sized chest films to prove to myself that what I thought I saw in the miniature film was, or was not, there. I learned, among other things, that muscles, posterior articular tubercles of the ribs, and long transverse vertebral processes could, especially in the apical regions of the chest, produce shadows deceptively suggestive of pathologic lesions. Gradually, however, I developed ability to make interpretations which were confirmed by standard-sized films, and at the same time my confidence in this new method of examination became established.

Perhaps special talent is required to interpret 35 mm. films, but it does take practice or experience to gain confidence in this form of examination. I wish to emphasize this need of experience, because I have heard medical officers express skepticism after viewing a roll of 200 films during their first day in our photofluorography unit. That is much too early to form such an opinion. In training medical officers at present, we use a set of 35 mm. films showing proved pathology, and another set of essentially normal films of good quality. With these films and daily practice in reading rolls of film, medical officers with previous radiological experience acquire confidence in photofluorography in a training period of one week.

QUERIES

We are often asked, "How small a lesion have you been able to detect?" Single lesions of soft quality, which appear to be one-quarter inch or less in diameter in the 14 by 17 film, are detected by our medical officers with photofluorographic experience. Calcified lesions of the apparent size of one-eighth inch or smaller in the standard-sized film, are readily seen. Accentuated broncho-vascular markings can be followed well out toward the periphery. We do not claim, however, that all small lesions are always discovered. The position of the lesion and the quality of the film are important factors in our successes and our failures.

Another frequent question is, "What do you believe your per cent of missed diagnoses is?" We cannot even estimate an answer to this question. A recruit remains at the Training Station from a few weeks to three months at most, and so all our errors probably do not have time to catch up with us. Up to the present time six cases of pulmonary tuberculosis have been found clinically in recruits, to whom we have given an essentially normal classification. Three of these were tuberculous pneumonias of the acute type, and we are not convinced that a lesion, demonstrable by radiography, was present in their lungs at the time of our photofluorographic examination. The other three were outright missed cases, for which we have found no valid excuse. The final answer to this question of missed cases will come from the statistics of the Bureau of Medicine and Surgery of the Navy after this war is won. The incidence rate for pulmonary tuberculosis among naval personnel before photofluorography was instituted, compared with the rate after photofluorography was started, should give an indication of the extent of our success or failure. We believe those future statistics will prove the great value of mass survey of the chests of recruits.

NAVY CRITERIA CONCERNING REJECTIONS FOR MILITARY SERVICE

The Medical Department of the Navy set the following criteria as causes for rejection:

(*a*) Any evidence of adult or reinfection type of tuberculosis, active or inactive, other than slight thickening of the apical pleura or thin, solitary fibroid strands.

(*b*) Evidence of active primary (childhood) type of tuberculosis.

(*c*) Extensive multiple calcifications in the lung parenchyma, or massive calcification in the hilum, or any calcification of questionable stability.

(d) Evidence of fibrinous or serofibrinous pleuritis, except diaphragmatic adhesions with or without blunting or obliteration of the costophrenic sinus.

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* Read before the California Trudeau Society and the California Tuberculosis Association, Fresno, April 7, 1943, in the symposium on "War-Time Tuberculosis Case Finding."

The opinions or assertions contained therein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the naval service at large.

(*e*) Miscellaneous disqualifying defects: pneumothorax, hydrothorax, chronic pneumonia, bronchiectasis, pulmonary abscess and tumors of the lung, pleura, or mediastinum.

CLINICAL MATERIAL

Cases diagnosed adult-type tuberculosis were also classified as active or inactive. It is to be regretted that the exigencies of the service made it necessary to transfer these patients to another Command immediately after diagnosis. For that reason our opinion as to the activity or inactivity of the disease was not confirmed by clinical or laboratory findings. With this admitted but unavoidable defect we give the following statistics. They are based on photofluorographic chest examinations made on recruits during the period from May, 1941, to December 31, 1942. All final diagnoses were made from chest radiographs of conventional size taken at six-foot distance.

Pulmonary tuberculosis, adult or reinfection type	131.8 per 100,000
Active	61.7 per 100,000
Inactive	70.1 per 100,000

* * *

Active primary	1.2 per 100,000
Multiple or massive calcifications	16.5 per 100,000
Pleuritis	12.7 per 100,000
Miscellaneous	10.1 per 100,000

COMMENT

In making the rejections for adult-type tuberculosis, we adhered closely to the Bureau of Medicine and Surgery's criteria; definite parenchymal foci, or two or more fibroid strands in the upper third of the lungs.

There were 26 rejections for multiple calcifications in the lung parenchyma. Eight of these were classified as healed miliary tuberculosis of the lungs because of the uniform size of the nodules and their even distribution. The other 18 were described as extensive healed primary type infections in our reports. This classification probably was an unnecessary refinement, and was definitely an arbitrary classification made entirely on consensus of staff opinion.

OTHER CAUSES FOR REJECTIONS

There were 16 rejections for miscellaneous causes. These were divided as follows:

5 mediastinal tumors
3 bronchiectasis
2 pulmonary cysts
1 asbestiosis
1 pneumoconiosis causative agent unknown
1 chronic interstitial pneumonia
2 pneumothorax
1 pulmonary abscess

ON PERSONNEL EXAMINED

In any deduction attempted from these statistics, one should remember that the Training Station was dealing with a selected group of individuals. They were young men, the great majority of them between the ages of 17 and 23. Most of the obviously unfit or diseased applicants were rejected at the Navy recruiting stations. Our recruits came from the Southern Mississippi Valley States, from the Southwestern States, the Rocky Mountain States, and the West Coast States. No Negroes were included, because Negroes were not trained at the San Diego station.

No statistics were kept as to geographical distribution of the cases, but my impression is that the incidence was slightly higher in the Mississippi Valley States and Texas than in the other districts from which we drew recruits.

COSTS TO THE GOVERNMENT

The cost to the Government in care and pensions of patients acquiring tuberculosis during World War I has been variously estimated from $10,000 to $25,000 per patient up to the present time. Assuming only $15,000 being the final cost for each tuberculous patient, and assuming, in addition, that none of our arrested cases was active and would not become active, the photofluorographic unit has saved the Government approximately $1,500,000. But it may be argued that most of these patients will ultimately be cared for at Government expense even though they were eliminated from the Navy soon after their enlistments. Then we in the photofluorographic unit still have the satisfaction of believing that we prevented additional cases of pulmonary tuberculosis by eliminating many possible sources of infection from the narrow living spaces of ships at sea and from the close personal contacts of naval barracks ashore.

I have had no experience with photofluorography on 4 by 5 film which is used in the induction centers and the U. S. Army. Therefore, I am not qualified to give an opinion as to the comparative merits of the two methods of examination. I am certain that the 35 mm. method of examination is a valuable and economical method of making mass surveys for pulmonary tuberculosis.

Naval Training Station.

EXPERIENCE IN INDUSTRY*

NEIL CLARK GODFREY
Napa

DURING the second week of February, 1943, the Basalt Rock Company, Inc., of Napa, California, conducted a fluoroscopic survey of its entire personnel for tuberculosis. We understand that such an undertaking was the first of its kind ever tried in the Bay region, and, in fact, that in several particulars it was unique in our national war on tuberculosis.

In retrospect it appears that this mass examination was a considerable success and constituted a concrete contribution not only to the public health of the community, but also to plant efficiency. It was a builder of employee morale in that it demonstrated to the men that the Company was interested in their personal well-being. Also, it served as a practical demonstration of the value and efficiency of modern disease detection.

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* From the Basalt Rock Company, Napa.

Read before the California Trudeau Society and the California Tuberculosis Association, Fresno, April 7, 1943, in the symposium on "War-Time Tuberculosis Case Finding."

At the outset the Company determined that the examination, if it was to achieve maximum results, should be entirely voluntary, strictly confidential, and that no discrimination should be shown regarding any individual case, irrespective of the ultimate findings. With this predesignation it became obvious that it would be necessary to stimulate interest to such a point that the response of the men would be spontaneous.

MECHANICS OF THE PLAN

To accomplish this the actual mechanics were handled by the personnel office.

First, and by reason of the personal background of a large majority of the men working in the yard, it was thought imperative to alleviate suspicion by conducting an intensive educational campaign designed to sell the necessity of coöperation. This was done through the media of posters, circulars, and personal contact by the leadermen and foremen. To this end, the yard was thoroughly billed; first, with general health posters, then with those emphasizing the dangers of colds and other similar ailments; and last, a week before the examination, posters showing the facts about tuberculosis, its dangers, detection, and cure. The day preceding the commencement of the examination, all employees received a circular giving a full explanation of the plan, its advantages and benefits. The fact that the examination was to be free and voluntary was particularly stressed. More important, however, was the fact that approximately ten days in advance of the examination a meeting was called of all of the departmental superintendents, shop foremen, quartermen and leadermen. This group was addressed by one of the personnel officers and by a local medical doctor from the standpoint of selling these men on the immeasurable value of 100 per cent participation. They were sold. Also, they were given information so that in turn they could sell their crews and answer the questions of the men.

Thereafter the foreman lists were grouped and scheduled with a coördinator or group leader in charge. This schedule consisted of a list of departments broken down into foreman groups and showing the name and badge number of the coördinator in charge. These men were selected with consideration as to their personalities and whether their positions required them to contact the men daily.

Well in advance of the examination a meeting of these coördinators was held and they were also sold on the merits of the examination. Again the necessity for a 100 per cent turn-out was emphasized.

The next step was to have appointment notices mimeographed, and about a week before the starting date these slips were filled in with the names and other pertinent data concerning each and every employee of the Company. After the appointment notices were completely filled out, the time was also filled in, in accordance with a time schedule. The time schedule gave the hours available, the shift, and the potential number of patients. Appointments were scheduled sixty to the hour, the times set being fifteen every quarter hour.

Our experience showed that twenty appointments each quarter hour could have been made safely. The next step consisted of delivering the appointments for the next succeeding scheduled examination to the various coördinators just before each shift. The pushers, in turn, delivered the notices directly to the men and then contacted each one of them later to see that no one forgot. At all times during the examinations one coördinator was put in charge as a supervisor. If any person was absent at the time of his appointment, or failed to take the examination for any cause, the fact was noted on the notice, which was returned to the office for possible resetting.

OTHER OBSERVATIONS

The Company prepared the examination quarters, which consisted of a dark room for the fluoroscope and a waiting room. The results of the examination showed that out of the 2,410 persons examined, 23 suffered from noninfectious abnormalities, requiring some routine medical check-up; 49 had visible heart irregularities; 63 questionable tuberculosis referred for x-ray and clinical study; 28 cases showed active tuberculosis and were referred for treatment; there were also three persons found to have possible malignancies of the chest. Thus, the total persons definitely in need of the examination were 166.

The statistics also showed that the total number of employees was 2,680. Of this number, 51 were absentees after several resets, 94 were terminated during the examination period, and 9 refused to take the examination on religious grounds. Thus, the percentage examined was 95.4 per cent.

A close check of the time consumed was kept. This showed that the average time lost per man was 19 minutes. This time multiplied by the average wage of $1 per hour amounted to $763.17. The total expense, adding time lost, cost of the examination room, extra secretarial service and doctors' fees, divided by the total examinations given, shows the cost to the Company to have been 48 cents per person examined.

REACTIONS OF THE EMPLOYEES

Before the plan was commenced, only a small number of the men appreciated the value of the fluoroscope. Many of the employees were not aware that such a machine existed. After the survey was completed, these men were convinced of its efficiency and value. The idea of having a machine that enabled the doctor to look inside their lungs appealed to their imagination. In a word, the examination was a concrete demonstration of its own worth and it inspired enthusiastic acceptance.

With only one exception, the positive cases were unaware of their condition before. But for the survey these men would have continued at their jobs until their condition was far advanced. And, of course, it goes without saying, that the potentialities of their contagion would have been far reaching. Statistics could never be compiled to show the total ramifications of the effort.

Actual experiences during the survey encompassed many extremes. In several instances the potential examinees stoutly announced that tuberculosis was merely a figment of man's unfaithful mind; that to submit to the examination would constitute a violation of their religious precepts. Another employee, a feminine welder, shyly but firmly insisted that the necessity of removing her leather welder's uniform before the fluoroscope amounted to a needless violation of her modesty. Upon being informed that her examination could not proceed without this preparation, modesty or no modesty, she blew out a storm of oaths that would have dwarfed the attempts of a longshoreman. However, the general rule was that all persons were enthusiastic and coöperative.

The responsibility for the actual conducting of the examination rested entirely upon the Napa County Association. Through its officers the attendants, nurses, and the examining physicians were provided. There were a great many "don'ts" that the Company was compelled to force on the examination attendants. Because of the fact that this company is a signatory of the so-called Master Agreement between the West Coast shipyards and certain labor unions, physical examinations cannot be made a condition of employment. For that and similar reasons the doctors could not be allowed to discuss their findings with any employee. The readings were given in code so that fellow employees, and even the man himself, were not informed of the findings at the time. Later the man and his family doctor were sent a letter showing the diagnosis.

The postexamination follow-up is now in progress. It is constituted by a program of calling at the homes of the affected persons; x-rays, where further diagnosis is in order; and the making of arrangements for hospitalization where such is required. The Company is giving such aid as it can.

CONCLUSIONS

Our conclusions, predicated upon our experience to date, are:

1. That in an industrial plant such as the Basalt Shipyard a survey of this type is a good investment, well worth the monetary expenditure.

2. That a well-organized campaign directed toward a large number of such industrial plants, with persistent postexamination follow-ups, would constitute the maximum contribution now possible in the present stage of the war against tuberculosis.

Basalt Rock Company.

CURRENT TRENDS IN INDUSTRIAL HEALTH *

T. S. Petersen
San Francisco

It is a pleasure to meet with the members of this association which has had an important part in the reduction of tuberculosis. My own company formerly had sanatoria for the treatment of our employees who had this disease. Of late years the number of such cases has been so greatly reduced that, with the improved general facilities available, it is no longer necessary for companies to operate their own sanatoria.

The reduction in suffering, as well as the reduction in the loss of productive time, and, therefore, income, which this decrease in tuberculosis has occasioned, is much appreciated by industry in general, and we are in hearty accord with the good results of the work which this group and other similar groups as well as the medical profession as a whole have achieved. At the same time, we realize that the fight against tuberculosis is one which must be constantly continued, and that this fight is even more necessary during wartime periods.

My viewpoint on tuberculosis control must, of necessity, be that of industrial management rather than of a professional approach to the subject. In considering the current trend in industrial health, it is assumed that there is some change from what has been the situation in the past. Accordingly, it may be well to consider, as a background, the usual industrial health program of a few years ago.

INDUSTRIAL HEALTH PROGRAMS IN PREVIOUS YEARS

While such programs varied widely in different companies, a fairly common one in larger industries might be described as follows:

1. *Industrial Injury First Aid.*—Nearly all companies where a fairly large number of employees were at work had provisions for giving first aid in cases of industrial injury. This is probably one of the earliest forms of industrial health and one of the most necessary. Even companies which did not have doctors and nurses in residence generally made some provision for the quick securing of nearby medical services for such injury cases.

2. *Preëmployment Examinations.*—These consisted of fairly complete physical examinations, primarily for the purpose of determining whether the individual would be liable to injure himself in the type of work for which he was being employed, or would endanger any of the employees with whom he was associated. More and more, as time went on, the doctor making these examinations was relied upon to indicate the type of work for which the individual's health or physical condition indicated he was suited. Thus, more and more the individual was protected. Furthermore, partially handicapped workers could in this manner be employed on types of jobs where their physical condition would be no detriment and their health would be protected.

3. *Periodic Physical Examinations.*—Many of the companies which provided for preëmployment physical examinations also provided for periodic examinations, say every two years up to some age such as 40 and every year thereafter. In this way some illnesses and diseases, or physical conditions, such as hernia, could be detected in early stages, and the examining doctor could counsel with the

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* From the Standard Oil Company of California.

Read before the California Tuberculosis Association, Fresno, April 7, 1943.

employee about securing medical treatment from his own physician.

4. *General Health Services.*—Activities under this heading were among those which differed most widely in different companies. In general, they were rather limited. Some companies had doctors and nurses in residence who were available for counsel and advice to employees when they were ill or in poor health, in which case a discussion of their condition and advice as to securing immediate medical treatment from their personal physicians could be given. Usually, in such cases where doctors and nurses were in residence, first aid in sickness cases was given. However, outside of such limited service as that alreadv mentioned, not many companies did much in the way of general health service.

From these earlier beginnings the industrial health program gradually expanded as management and employees both became more interested in the benefits of good health. It has been our experience that employees, particularly the older ones, have been increasingly active in asking for more general interest in health problems. At the present time, during the war period it is very important that our productive capacity be maintained at its highest level. With manpower playing such a critical part in producing goods necessary for the war, all the time which can be saved from sickness is a direct contribution to the war effort as well as a personal benefit to the individual.

To complicate this industrial health problem, during the war period we have many changed conditions. With a large influx of workers to some of our Pacific Coast areas, with the consequent crowded living conditions and often unsuitable housing, the health conditions at home are not as good as they formerly were. In addition, many of the men are working longer hours, which contributes to fatigue and decreases recreation periods. Food rationing has made it difficult in some cases to secure as much of the more essential foods as could formerly be obtained. At the same time, the great demands on the services of medical men in the armed forces, as well as in the growing communities, has resulted in some cases in a shortage of available medical service.

CURRENT INDUSTRIAL HEALTH PROGRAMS

All of these factors together lead rather naturally to a growing interest in industrial health and, for that matter, in public health. On the industrial health side, and undoubtedly in public health as well, interest is being centered in the prevention of sickness rather than the cure. This leads to a review of some of the current trends as industry sees them, and which can perhaps be discussed under the following seven points:

1. *Encouragement of Improved Living Habits.* I believe medical men are responsible for convincing industry that the foundation of good health is good living habits. One of the most important of these is proper eating. Accordingly, the medical divisions of many large companies are interested in educating the workers on good eating habits. Such education consists of articles published in company magazines, in holding classes in nutrition for the wives of workers, in making available information concerning vitamins and the part they play in good health, and even the distribution of cook books explaining what can be done with the foods available under rationing.

In other words the effort is to provide the properly balanced diet for the type of work which the individual performs. The company physician himself does not necessarily handle the details of such a program, but under his direction nutrition experts, or others skilled in this field, can carry on the work. Some of the public utilities and certain other companies have such people attached to their staff who are available to industries in nearby communities for conducting classes or advising on such programs.

Also, there is an increasing trend toward the furnishing of hot lunches in company cafeterias or lunchrooms, and the provision of warm drinks on the night shifts. If such activities as these contribute to generally improved health, they certainly are worthwhile, and I have no doubt that there may be some expansion along these lines from public agencies as well as from industry.

Then, also, there is encouragement of obtaining sufficient and proper sleep, regular exercise, regular bathing and other good living habits.

2. *Prevention of Common Ailments.*—Under this general topic come such efforts as the prevention of the common cold which, apparently, in our company at least, accounts for one-third of all time lost due to sickness. Industry, as well as the public, would eagerly welcome a "sure fire" method of eliminating this practically universal complaint. I am not sure just how the medical profession generally regards cold remedies or preventives, but many industries are trying out some of those now on the market. My own company is currently making a test of oral cold vaccines on about 5,000 employees with a view toward trying to determine how effective they are in preventing colds. Along with these vaccines we give a small pamphlet on good living habits.

Some companies have tried furnishing vitamin capsules to their employees while others have held to the view—based upon their own medical division's recommendation—that vitamins can best be secured through the use of proper foods. In any event, there appears to be a definite trend toward taking an interest in the prevention of some of these minor ailments which contribute so much to the discomfort of the individual and to lost time from sickness.

3. *General Health Education.*—There is also an analytical approach to the industrial health problem which lends itself to both individual health education and general health education. By keeping track of employees who are frequently sick, the physicians can determine where help is apparently needed. A personal interview by the company physicians with such individuals, and advice and counsel on some of the matters already mentioned, such as eating habits, recreation habits and general

care of the health, in many cases considerably assists the individual. Such interviews often result in examination, and then if medical treatment appears necessary, advice for securing such treatment from his personal physician is given.

As a result of such investigation of individual cases based on sickness records and similar data, the points on which it appears desirable to give further information to employees in general are determined, and such information is presented through articles in company magazines, by slide films in weekly safety meetings or in connection with periodic examinations.

As a direct service to the general education in health matters, many industries have taken steps to encourage the employees to seek the advice of the company physician when they are not feeling well. This is extended in some cases even to giving them advice on the prevention of having that "morning after" feeling.

There is one ailment I have not mentioned, but which I believe is worthy of consideration, and that is "worry." Today there are many reasons for employees worrying—they may have sons on the battlefronts or about to go, or they may be about to be drafted and have to leave a wife, or they may not be able to secure suitable housing or any one of the many other things that are so disturbing today. Toward the last of the year just past we found a sizable increase in accidents occurring. Somewhat by chance we found a slide film that dealt with how to treat your personal worries. This was shown at our regular safety meetings, and many employees commented on the sensible viewpoint shown by the firm, and that "it was a good thing to keep in mind." Our accident record improved markedly—maybe the film helped. At any rate, the problem of worry is here today, and I believe is worth considering as a factor in industrial health.

4. *General Medical Services.*—More and more industry is tending toward giving medication for minor ailments, such as treating colds, poison oak and similar sicknesses which normally receive no treatment at all or at best only home remedies.

In some cases they give eye examinations to determine whether the employee should take steps to procure glasses. My own company has had some experience in this connection. Although we have always given eye examinations in connection with either preëmployment or periodic physical examinations, we went a step further in connection with our safety work, and gave auto driving eye examinations to drivers of our motor vehicle equipment. A surprisingly large number of drivers required corrective glasses; and while the program was entirely voluntary, some 94 per cent followed up the examination and secured such eye glasses as were necessary. In this particular phase of our work, as is the case in many such situations, the results of the examination on any individual were confidential between the safety engineers giving the test and the employee, and were not made known to supervisors or management. The fact that individuals received the program so well and followed it up so completely seemed to indicate to us that they were very interested in correcting any eye deficiencies which they may have had.

A few companies have even gone to the extent of having psychiatric services available for their men as an aid in proper placement on the job and in helping to reduce or eliminate mental difficulties. However, very few industries provide general medical services, most of them limiting such services to minor ailments and counsel and advice.

5. *Working with Community Health Agencies.* Due to poor living conditions in crowded areas and the other effects of the war emergency, the medical divisions of large industries have been more and more interested in working with community, state and federal health agencies toward the improvement of public health conditions. Industry recognizes that this is a valuable service, both to public health as well as to industrial health.

6. *Medical Services in Connection with Safety Work.*—While most large industries have a safety division, there is an increasing trend toward having that division and the medical division work together on improving health. The doctor can assist in making inspections of working conditions, examining sanitary conditions and watching the new processes or new materials handled for dangers to health.

The employment of many women in our industries has created new conditions and the medical division's consideration of such matters as fatigue and working conditions for women is being requested more and more.

In addition, the medical division is being relied upon for the placement of handicapped or physically impaired people, and a first hand knowledge of the type of work performed on the job is important in this connection. Increasing emphasis is being placed on healthful postures and appropriate surroundings.

7. *Provision of More Medical Services for Employees.*—With the increasing interest of employees and the public generally for more available medical service, some industries have helped in the establishment of hospital or medical plans. Such general medical services are now under study by governmental agencies. The trend seems to be toward some plan or plans to provide the individual with more medical assistance than has been the case, and as this is so important in employees' minds industry is also becoming interested in helping through some appropriate means to assist in the matter.

The points I have mentioned are some of the highlights on current trends as I see them.

SUMMARY

1. The trend is definitely toward industry putting forth greater effort to improve industrial health.

2. Attention is being directed to more education for employees on health matters, on good living habits, on better working practices, and on seeking more advice and counsel on illnesses.

3. The trend is toward providing more medical services for employees—through first aid on minor illnesses and, perhaps, through medical plans or similar plans for the more severe illnesses.

Standard Oil of California,
225 Bush Street.

COMPULSORY HOSPITALIZATION OF RECALCITRANT TUBERCULOUS PATIENTS*

Edward Kupka, M. D.
Los Angeles

Ultimate Control of Tuberculosis.—The ultimate control of tuberculosis rests on three factors:

1. Find the persons affected with the disease, particularly those who excrete bacilli. The great accent of today's tuberculosis campaign is upon this factor. Early diagnosis campaigns, x-ray surveys of the apparently well, follow-up of contacts, special attention to certain racial, industrial, and age groups, school surveys with investigation of the families of reactors, are some phases of this effort. Here the voluntary associations and official agencies work in close coöperation. With the advent of the small x-ray film and increased federal participation, such as examination of Selective Service men, and the establishment of a Tuberculosis Bureau in the United States Public Health Service, case finding has felt a tremendous upsurge the last one or two years, and bids fair to become very extensive as time goes on.

2. Hospitalize those patients who need it. This phase has seen increasing governmental participation at all levels. The care of the tuberculous is now accepted as a necessary function of tax-supported institutions. Such tremendous strides in this field have been taken during the past twenty years that the bulk of the building may be considered as accomplished, except for certain corners of the country. Whether we can agree or not with Doctor Drolet's paradoxical hypothesis that collapse therapy does not affect the death rate, there is no disagreement as to the value of the sanatorium as a place of isolation. Without sanatorium beds in which to put communicable tuberculosis the value of case finding would be lessened materially.

3. Establish the legal power to make it possible to bring suspected persons in for examination and to compel isolation, if communicable tuberculosis can be demonstrated, when the patient is unwilling to take the necessary steps voluntarily. This function, which is entirely a governmental one, has not been widely practiced. As a rule the tuberculosis programs have been directed toward those who willingly came for examination and hospitalization, while those whom urging and explanations failed to win over have been spared the penalty of compulsion. The era of generalized tuberculinization of the population has long passed. It used to be that for every person who was persuaded or compelled to enter a sanatorium there would be several other spreaders left in the population to keep the chain of tuberculous infection unbroken. Today, when in many states and counties there are adequate beds for all who need them, the uncontrolled known spreader calls for action.

ON EXTENT OF COÖPERATION

The vast majority of the tuberculous are coöperative. The incorrigible form a small per cent of the total. The problem does not loom large on the basis of their proportionate number of incorrigibles, but upon their magnified potential for harm to the community. If they are out of an institution, they are characterized mainly by their wilful commingling with the community and by failure to take precautions at home. In the institutions they become disciplinary problems, refuse to take the rest cure, upset the other patients, and usually leave without consent. The handling of this group, in or out of the sanatorium, is a strain upon the kindest doctors and nurses. From the standpoint of public health, it is the extramural patient group which is the most important, and most of the remainder will be extramural for significant periods, since going home without consent is a characteristic of the group.

THE INCORRIGIBLES

Who are the incorrigibles? They are persons suffering from active tuberculosis, whose sputum is grossly positive, who, after many warnings and attempts at hospitalization, continue to conduct themselves in such a manner as to endanger their families and their community. What makes them incorrigible? Certainly not the tuberculous infection. Most of the incorrigibles would be problem men and women even if they did not have tuberculosis. Some are chronic alcoholics—the variety that drifts in and out of local jails, and in and out of state mental hospitals. A significant portion is comprised of borderline psychotics—not insane enough to convince a jury that they are commitable to a state institution, but sufficiently unbalanced to be antisocial and difficult to handle. A few are narcotic addicts or ex-addicts. Some of the incorrigibility is due to simple ignorance and fear. A few are average individuals who have accepted hospitalization, and, finding it not to their liking, decide to make such a nuisance of themselves that, in self-defense and to maintain the morale of his institution, the medical director is compelled to expel them.

Our social service friends urge us not to forget that each of the recalcitrant tuberculous is, first of all, a human being, and, further, a wretched human being, who is reacting understandably to a difficult situation. For these reasons, they urge us to approach the patient as tactfully and kindly as possible. I am sure that, in the vast majority of cases, physicians, nurses, public health officers, social workers, ministers, and understanding relatives, all have exausted the usual considerate means of approach. The difficult patient who will react favorably toward decent treatment and adequate explanation is not incorrigible. It is only when these means have been found ineffectual that the problem calls for other than the humane approach. It has been truly said that one difficult patient can cause more headache to a health officer or to a sanatorium director than the collective problem of several dozen coöperative patients.

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* From the State Department of Public Health, Los Angeles.

Read before the California Tuberculosis Association and the California Trudeau Society, Fresno, April 7, 1943.

Granting, then, that all customary methods have been tried to bring the patient into line and have failed, what legal machinery can be invoked to cope with this menace to public health?

We naturally turn to the State Health and Safety Code as the final legal authority for all the powers of health officials, and we find there, under Section 2554, this regulation:

> Each health officer and coroner knowing or having reason to believe that any case of—and here are listed thirty-four communicable diseases, including tuberculosis—or any other contagious or infectious disease exists or has recently existed within the territory under his jurisdiction, shall take such measures as may be necessary to prevent the spread of the disease.

COMMENT

I leave to Mr. Martin, who will discuss this subject from the standpoint of a lawyer, elaboration upon the powers thus given to the health officer; but I emphasize here that they include the orders of isolation served upon tuberculous individuals.

In another section of the Health and Safety Code, similar powers are given to the State Department of Health, which may step into a jurisdiction, when the local authority neglects or cannot perform its function, and enforce similar powers. So we find that both the local health officer and the State health officer have this power; but, from a practical standpoint, it is hardly ever used by the latter, and is reserved for emergencies, as, for example, a plague epidemic, when the local jurisdiction could not handle the situation.

Most health officers are aware of their power in this matter. They feel the need of the power in connection with the recalcitrant tuberculous and would like to bring them to bar. However, in some counties they have been unable to convince the district attorneys. Sometimes the district attorneys will point to the section giving the State health officer that power and ask for an order from the State before legal action is begun. However, such orders have not been forthcoming for the reason given above. Some district attorneys, and, it must be said, some health officers, too, feel that they cannot act as directly in a chronic disease like tuberculosis as in an acute disease like smallpox, and fear that public opinion would not be behind them. It is a fact that in most of the counties of this State there has never been a single order of isolation issued against a tuberculous person, and, therefore, for the officials of those counties it would be a step in a new and untried field fraught with unanticipated developments. Obviously, the health officers cannot go far without the coöperation of the district attorneys if penalties are to be imposed for the breaking of isolation.

EXPERIENCES IN LOS ANGELES COUNTY

The extensive and enduring experience of Los Angeles County indicates that only a small fraction of those upon whom orders of isolation are served need ever be taken to court. The majority obey the orders. Even the jail sentence does not in fact turn out to be as cruel as it sounds, since the majority of those sentenced are paroled to the sanatorium and are sent to jail only if they again break isolation. Doctor Telford will be able to tell us more of the details in his discussion. It would seem highly desirable for other counties to follow the aggressive and successful methods of Los Angeles County.

Three weeks ago a meeting was held in Los Angeles to debate the topic now under discussion. Sanatorium physicians, health officers, social workers, and others, were invited to participate. Many phases of the matter were roundly thrashed out. Some of the constructive suggestions made are incorporated in the remaining paragraphs of this paper.

Granting that we have the problem, that it is a big problem, and that we have the machinery to handle it, there remains the task of fitting this machinery to an individual patient. Degrees of communicability are varied, the various personal problems of the recalcitrants are many, and the number and quality of available beds in which to isolate them differ widely from county to county. It may be truthfully said that some counties cannot, by virtue of their special situations, handle the matter as other counties do. Mono County, with 1,400 people, scattered over a wide area, and no beds for tuberculosis, cannot do the same as San Francisco County.

SOME GENERAL PRINCIPLES

However, there are certain generalizations which hold for all counties, and to help make the isolation of the incorrigible more effective and more easy, the following proposals have been made:

First, the regulations of the State Department of Health regarding communicable disease should be strengthened in regard to tuberculosis. This has been done by Doctor Wynns, State Epidemiologist, who recently revised the regulations for all communicable diseases, and in the new version which was recently adopted by the State Board of Health the following phrase is added to the section on tuberculosis:

> Patients afflicted with tuberculosis in a communicable stage who refuse to observe the health officers' instructions and thereby expose others needlessly to infection shall be placed in quarantine; and in the event that such quarantine proves inadequate for the protection of members of the household or the community the patient shall be placed in isolation in quarters designated by the local health officer until such time as such quarantine or isolation is no longer necessary for the protection of the public.

This regulation is very specific and provides for either quarantine or isolation. It also makes the local health officer the deciding authority in the matter, which is as it should be.

Parenthetically, it may be agreed that quarantine has little or no place in the control of tuberculosis. Isolation is the necessary method. In the above regulation, quarantine is mentioned first for the sake of completeness, and, second, because the

Health and Safety Code stresses the word "quarantine." Property is quarantined, of course, but persons are isolated.

A *second* method of improving the situation would be to convince those health officers who do not believe so, that they have this power of isolating the tuberculous. There are some who, if reassured as to their power, would not hesitate to use it. There is, too, a group of health officers who know they have the power, but hesitate to apply it. Some of the reasons are intimately bound up with the feeling tone of other officials of the county.

Thirdly, the district attorneys about the State must be shown that when the health officer wishes to bring a case before the court on the charge of breaking isolation he must be supported legally by them. We have now a clear statement from representatives of the Attorney-General's Office that, under these circumstances, it is the duty of the district attorney properly to prepare the case and to prosecute the recalcitrant before the court.

The health officer must remember that the burden of proof is upon him to establish the communicability of the patient. He must have a "good case." It goes without saying, to begin with, that since action is usually considered only in the most obvious cases there should be no difficulty in making an acceptable brief. On his side the attorney must prepare the case adequately.

The usual criterion of communicability is a "grossly positive" sputum. This is taken by most to mean bacillus demonstration by an *unconcentrated* smear of the sputum. But this is not the only criterion. A large cavity might lead into a temporarily blocked bronchus, which would result in a temporarily negative sputum. Or evidently active disease might be present in a patient who would bring in someone else's sputum. The health officer should utilize additional methods and verify his opinion, and gastric lavage is one way of getting the sputum from the right individual. The Health and Safety Code provides power of examining persons "suspected" of having a communicable disease. Again the district attorney's insistence is necessary in the bringing of a recalcitrant to examination.

A *fourth* suggestion which is attractive to many is the creation of a State sanatorium which would be reserved for certain special categories of patients. Even if we did not have the incorrigible to deal with, we would still need a State sanatorium for patients who have State but not county residence, for patients who are nonresidents awaiting return or are not returnable to their home communities, and for patients coming from the smallest counties which have no tuberculosis bed facilities at all. Such a State institution could also have a locked ward to which judges could sentence the incorrigible tuberculous. This would do away with the disadvantage of keeping isolation breakers in a small prison in close contact with other prisoners. It would save the morale of institutions to which otherwise such a patient would be sent, and where he would have a demoralizing effect. Further, the very existence of such an institution, when known generally throughout the State, would act as a deterrent to the would-be incorrigible. Sometimes, as has been brought out by others, judges hesitate to send patients to tuberculosis facilities which are of unsatisfactory grade. The type of medical care in this proposed State institution could be of such high quality that there would be no question as to the advisability of sending a patient there.

Fifthly, all institutions for the care of the tuberculous should immediately report the identity and status of communicability of every discharged case to the local health officer. This is especially important when several counties are served by one sanatorium.

Lastly, as has been emphasized by everyone who has written or spoken of this problem, we must intensify our campaign of educating the public in regard to the dangers of tuberculosis. A certain amount of soft-pedaling has come into our publicity to take the horror-story coloring from tuberculosis; but no amount of softening can hide the fact that it is a disagreeable and deadly disease, and that those who wilfully expose others to it are as guilty of a breach in human conduct as those who poison food or kill by more violent means. The public must be told the danger in plain words. Here the voluntary associations, with able use of publicity media, can help a great deal. When the menace of the occasional uncoöperative and defiant vectors of infection is sufficiently emphasized, an aroused public opinion will demand the effectual control of such individuals.

State Department of Public Health,

COMPULSORY HOSPITALIZATION OF RECALCITRANT TUBERCULOUS PATIENTS *

Allen L. Martin
Sacramento

One of the most important of all health regulations is that directed to the exclusion of communicable diseases and the keeping of such diseases, when they once gain an entrance, within the smallest possible limits and providing for the establishment and enforcement of regulations by which their general dissemination shall be prevented and their continued existence rendered improbable or impossible. Power to make quarantine regulations is one of the most frequent powers conferred upon boards of health. The authority of health officers or boards of health to quarantine for scarlet fever, diphtheria, smallpox, measles, and other such common maladies, is so well recognized, both as a practical measure and by judicial endorsement, that any comment concerning such authority would be superfluous. However, it appears that no definite steps have been taken with respect to the quarantine of those infected with tuberculosis. An examination of several of the leading law digests has failed to uncover any cases in which definite judicial endorsement has been placed upon the power of health officers or boards of health to quarantine for such a disease.

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* From the office of the Attorney-General, State of California.

An opinion. Read before the California Tuberculosis Association and the California Trudeau Society, Fresno, April 7, 1943.

ON POWER TO QUARANTINE

However, it is my opinion that health authorities—at least in the State of California—have the power to quarantine in case of an active case of tuberculosis. It is expressly provided in Section 2558 of the Health and Safety Code:

> Whenever, in the judgment of the State Department, it is necessary for the protection or preservation of the public health, each health officer shall, when directed by the State Department, do the following:
>
> (*a*) Quarantine and disinfect persons, animals, houses or rooms, in accordance with general and specific instructions of the State Department.

Health and Safety Code Sections 2561 and 2563 provide the mechanics for such quarantine.

Health and Safety Code Section 2554 provides, in part, that "each health officer . . . knowing or having reason to believe that any active case of . . . tuberculosis . . . or any other contagious or infectious disease exists, or has recently existed, within the territory under his jurisdiction, shall take such measures as may be necessary to prevent the spread of the disease."

Health and Safety Code Section 2524 provides, in part, that the State Department of Public Health, upon being informed by a health officer of any contagious, infectious, or communicable disease, may take such measures as are necessary to ascertain the nature of the disease and prevent its spread. The section further provides that the State Department may, if it considers such action proper, take possession or control of the body of any living person in order to accomplish the purposes authorized by this code section.

Health and Safety Code Section 2571 classifies tuberculosis as a "reportable" disease. The last paragraph of Section 2571 provides that any of the diseases enumerated in the section and classified therein as reportable, and such others as from time to time may be added by the State Department, shall be quarantined whenever, in the opinion of the State Department, that action is necessary for the protection of the public health, and shall be isolated whenever, in the opinion of the Department or health officer, isolation is necessary for the protection of public health.

Health and Safety Code Sections 200-209 vest the State Department of Public Health with blanket authority to take all reasonable steps and measures to protect and preserve the public health. Thus, since the Legislature has recognized tuberculosis as a contagious, infectious and communicable disease, and in one of which sections (Sec. 2571) specific authority to quarantine is given, it cannot be contended successfully that the health departments or health officers are without authority to quarantine and isolate for such a disease.

The courts in this State, as well as in other states, have recognized that it is sound public policy for health authorities to take reasonable steps to prevent the spread of diseases.

Grover vs. *Zook*, 87 Pac. 638;
Adams vs. *City of Milwaukee*, 129 N. W. 518;
In re Johnson, 40 Cal. App. 242;
In re Culver, 187 Cal. 437;
In re Arata, 52 Cal. App. 380;
In re Travers, 48 Cal. App. 765.

COMMENT

While the powers of health authorities are very extensive and will be upheld whenever possible, and every presumption indulged in to sustain the validity of their action, their powers are not absolute. The power to quarantine must be exercised only when public necessity demands it within reasonable and fair apprehension, and not on mere suspicion. Whether a quarantine order is justified depends upon the facts of each individual case. A condition precedent to the exercise of the quarantine authority is that the health officer shall know or have reason to believe that the disease exists or has recently existed (Health and Safety Code, Section 2554). In the exercise of this unusual power. which infringes upon the right of liberty of the individual, personal restraint can only be imposed where, under the facts as brought within the knowledge of the health authorities, reasonable grounds exist to support the belief that the person is afflicted as claimed. Where a person so restrained of his or her liberty questions the power of the health authorities to impose such restraint, the burden is immediately upon the latter to justify by showing facts in support of the order. It might be proved. for instance, that the infected person had been exposed to contagious or infectious influence; that some person had contracted the disease from him or her, as the case might be. Such proof would furnish tangible ground for the belief that the person was afflicted as claimed.

In re Arata, 52 Cal. App. 380;
In re Milstead, 44 Cal. App. 239.

More than mere suspicion that the individual is afflicted is necessary to give the officer "reason to believe."

In re Shepard, 51 Cal. App. 49;
In re Dayton, 52 Cal. App. 635.

If reasonable cause to believe that the person involved is afflicted with a quarantinable disease, the person may be quarantined upon a preliminary examination.

In re Milstead, 44 Cal. App. 239.

Under date of March 7, 1941, the Attorney-General's office ruled that the Director of the Department of Public Health was authorized to request the health officers of a certain locality in the State to quarantine an active case of tuberculosis. (Opinion NS3330.)

CONCLUSIONS

1. Health authorities are authorized to quarantine for an active case of tuberculosis, upon the basis of the provisions of the Health and Safety Code, hereinabove referred to, in addition to the theme which is present in all court decisions construing these and similar health laws.

2. This authority must be exercised prudently. Reason to believe that the disease exists as a prerequisite to the quarantine must be present. The burden is on the health officer to show that reasonable cause exists.

What constitutes reasonable cause depends upon the peculiar facts of each case. The duration of the quarantine and other conditions of the same are left to the rule-making discretion of the health authorities.

Attorney General's Office.

COMPULSORY HOSPITALIZATION OF RECALCITRANT TUBERCULOUS PATIENTS *

J. O. Raffety, M. D.
San Francisco

FORTUNATELY, in both counties in which I have served as health officer, I was second, and thereby profited from the experience of my immediate predecessors, both of whom were excellent men, but moved too fast for the people of the community.

I sincerely honor and respect those in the Los Angeles County Health Department who have been successfully isolating tuberculous cases, and believe that others should follow suit. I do also believe, however, that the young health officer in a young department should bide his time and first develop the community organization.

On one tuberculous patient whom I felt sure should be quarantined, my District Attorney advised me not to get into court with the case, primarily because the family would no longer be self-supporting and would have to go on relief. This is not a criticism of the District Attorney, but a criticism of a lack of community health viewpoint.

Until such time as the community is ready to accept its responsibility, and until social welfare departments are enabled to properly care for the dependents of the isolated tuberculous patients, the young health officer is dealing with political dynamite.

There is another reason why the young health officer has to go slow in quarantining tuberculous cases. In one county there were about twenty families who were related. One of the men in one of these families had a chest x-ray to support the clinical evidence of a broken rib, and far-advanced pulmonary tuberculosis was diagnosed. He reluctantly entered a sanatorium one hundred miles away from home, and there was considerable dissension in this whole clan.

Shortly thereafter a mother of two preschool children was found with a large cavity in the left lung and positive sputum. It took our department six months and visits by different department members over that period of time to finally get this mother to voluntarily enter the sanatorium. I do believe that had we quarantined the first or second case it would have been considerable time before we could have obtained the coöperation of other members of this clan, out of which we found other cases of tuberculosis.

Another point is that after perhaps working for months to find a case and to induce the patient to enter the sanatorium, the next thing the young health officer knows is the case has been discharged from the sanatorium without his knowledge for "cause." Then he is faced with the possibility of making a place of isolation out of a house that is already too small for the number of persons that are forced to live under one roof.

May I summarize by saying that although I heartily agree with Doctor Kupka and feel definitely that something should be done, in the light of my experience I feel that the young health officer should first develop his community organization and public health ideals in the community before tackling this serious problem. Community health organization is his greatest task in the beginning. He should not jeopardize his whole program perhaps for several years to come by tackling this isolation problem first.

The mere appointment of a health officer in a county does not solve the public health problems overnight.

1. Community health organization must first be well established.

2. The community must adequately accept its responsibility for the care of dependents left by forcibly isolated tuberculous patients.

3. There must be a place where the recalcitrant tuberculous patients can be kept so that the more obstreperous ones are not the ones that the health officer has to be continually dealing with.

I feel that local tuberculosis associations have a lot more work to do before the young health officer can put his excellent theories into actual practice.

State Department of Public Health,
Phelan Building.

COMPULSORY HOSPITALIZATION OF RECALCITRANT TUBERCULOUS PATIENTS *

P. K. Telford, M. D.
Los Angeles

TRUDEAU stated, in 1905, "Education of the people and, through them, of the State is the first and greatest need in the prevention of tuberculosis." Progress made since that time in teaching the patient and the general public the lesson of prevention cannot be overestimated. There remains, however, an enormous amount of necessary work to be done in this field. If surveys are promoted to universal application and collapse therapy is applied to its maximum effectiveness, it will still be necessary to apply more intensive supervision over the communicable cases, and a health department order of isolation in a considerable percentage before the spread is stopped. Public education will still be the necessary implement. It must be generally known and accepted by the public that an immediate increase in public cost is necessary, but that the result will be a great saving in the tuberculosis budget in a very few years. Health workers are well aware of the difficulty of selling health safety measures to the public. It requires the assistance of specialists in this sort of publicity, and in particular the endorsement and backing of this Tuberculosis Association. There is still a prevalent attitude of complacency toward tuberculosis, as each individual feels that he will never become a victim. He has a fixed conviction that his family is so resistant his protection is assured. We must teach him the fallacy of this attitude and induce him to shoulder the cost of keeping the dangerous case away from him, of treating the patient, and accepting all the social adjustments entailed.

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* From the State Department of Public Health, San Francisco.

Discussion on symposium, "Recalcitrant Tuberculous Patients," before the California Tuberculosis Association and the California Trudeau Society, Fresno, April 7, 1943.

* From the Los Angeles County Health Department, Los Angeles.

Discussion on symposium, "Recalcitrant Tuberculous Patients," before the California Tuberculosis Association and the California Trudeau Society, Fresno, April 7, 1943.

You might wonder why emphasis is put on these more or less intangible and extraneous factors when there are so many questions of detail to settle. After considerable experience with the program over a long period of years, we feel that nothing matters much but this. If the public wants it, it will work; and if they do not want it, it will not work regardless of state laws or how well they are applied. If a menace exists and the public wants protection, the worker will meet the challenge and do as good a job as his tools permit. The fundamental training of medical workers has so indoctrinated them with the responsibility of humanely treating the sick that we need have no fear of intentional misapplication of this authority.

As the basic needs of segregation become better understood, I predict that isolation in the home will be found practicable in many more instances when sanatorium treatment is complete or not indicated for any reason. However, satisfactory home isolation requires considerable supervision and an honest desire on the part of the patient to make it successful. The great majority of patients will coöperate when the need is understood; but there will remain the dregs of alcoholics, borderline mental patients, the spoiled self-willed, and the mean persons who need restraint and must be handled with more or less force, as do all enemies of society.

County Health Department.

THE X-RAYING OF SCHOOL PERSONNEL*

R. R. Newell, M. D.
San Francisco

THE present concept of the dominant pattern of the natural history of human tuberculosis is: a primary infection usually in childhood, recovery leaving perhaps visible scar in lung and occasionally calcification in tracheobronchial lymph nodes, and an invisible alteration in tissue sensitivity to the biologic products of the tubercle bacillus. A reinfection of the disease at a later time, most often along in the decade after puberty, with the likelihood of developing into the adult type of the disease which was for so many years known by the descriptive name of "consumption of the lungs." It is in this stage that caseation and liquefaction and cavity formation with ulceration of mucous membrane can develop, and it is such cases that spread tubercle bacilli to infect and reinfect the rest of the population. To call such "open cases of tuberculosis" calls attention to the fact that they are the ones that are dangerous from an epidemiological standpoint.

It is well known that there are many "cases" of open tuberculosis who are unaware that they are suffering from tuberculosis, and that there are some who are unaware even that they are ill. To discover them, therefore, and remove them from the streets and public buildings where they are a health menace to everyone not already reinfected with tuberculosis, it is not sufficient to demand that the general practitioner report them to the department of health. There are too many of them who do not go to see a physician. It is necessary to comb the population for such cases, and the finest comb that we have available at present is the x-ray film of the chest.

SCHOOL ENVIRONMENTS

In the schools we have a social mechanism which brings large numbers of children into repeated contact over long periods of time, and so is ideal for the spread of infectious diseases. We know, however, that open tuberculosis in childhood is uncommon, and that the primary infections with tuberculosis in children are not much of a contagion hazard because: when, the child is acutely ill he is at home, and later when he returns to school he has recovered. Therefore, one concludes that the children are not much of a tuberculosis hazard to each other.

The teachers and janitorial and secretarial personnel of the schools are, however, of the age group which may suffer from open tuberculosis; and, in fact, we know from the statistics of surveys in many places that from three to ten in a thousand may be expected to have the adult or reinfection type of pulmonary tuberculosis. Some of these will actually be open cases that are spreading tubercle bacilli. Among the 3,000 employees of the public schools of San Francisco one may, therefore, expect between ten and thirty persons who are actually or potentially spreaders of tuberculosis. Tuberculous sputum from one such person dried upon the floor has really an excellent chance at several hundred children, some of whom will have started school with a negative tuberculin reaction, and so be candidates for a primary tuberculous infection; and the rest of whom will have started school with a positive tuberculin reaction and so presumably be candidates for reinfection with tuberculosis if the dosage of bacilli inhaled or swallowed is sufficiently large.

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* From the University of California, San Francisco.

Read before the California Tuberculosis Association, Fresno, April 7, 1943.

EXTRAMURAL ENVIRONMENTS

What the relative danger between the schoolroom and the street and the home is, cannot be answered with certainty. It is surely not sensible to spend all one's available health funds on the schoolroom and leave the street and the home uncontrolled if the child is reasonably sure to pick up an infection outside the schoolroom anyway. However, considering the goodly incidence of negative tuberculins among children of teen age, one must conclude that it is by no means certain that a child will get tuberculosis from his exposure in street and home (and movie theater, and so forth, and so forth). I think, therefore, it is reasonable to give a high presumptive importance to the large number of susceptible children who will be exposed to tubercle bacilli from a single tuberculous teacher.

There are available four or five roentgen methods of tuberculosis survey: fluoroscopy, 35 mm. miniature fluorography, 4 x 5 miniature fluorography, 14 x 17 full-size paper, 14 x 17 full-size films. These increase in efficiency about in the order named. Their cost also increases about in the order named, although fluoroscopy is somewhat more consuming of the physician's time, and so its place in the economic series depends upon how adequately one pays the fluoroscopist; or to put it another way, how much free service one can get from public-spirited fluoroscopists. All of these methods have been used with some success in general population surveys. Although the cost per person examined is not terribly high, yet the incidence of tuberculosis in a population is so low that the cost of catching each individual case of tuberculosis mounts up to several hundred dollars.

SAN FRANCISCO'S EXPERIENCE WITH FLUOROSCOPIC SURVEY

We have in San Francisco some experience with a fluoroscopic survey, part of which was carried out in Chinatown where the incidence of tuberculosis is high; and which turned up a considerable number of cases. It is interesting to observe that about 20 per cent of these cases turned out to have been lost to follow-up, and no one can now say for sure whether those cases of tuberculosis are under a physician's care nor even know whether they are still in San Francisco. In such a situation it becomes a matter of secondary importance whether one case-finding method is 90 per cent efficient or only 85 per cent. If the more efficient method is more expensive, it might be an overall economy to choose the less expensive case-finding method, and use the money saved to better the efficiency of the follow-up.

In the case of the teachers and the other school employees, however, the matter is quite different, for practically none of these will be lost to follow-up—one does actually know where they are all the time. If any of them should disappear from follow-up it would be because he had left the school, and so would no longer be such a hazard to the school children of San Francisco. Under these circumstances, therefore, one must measure the increased cost of the more efficient methods of case finding against the presumptive cost to San Francisco of one missed case whose continued presence in the school might easily mean the production of one or several extra cases of reinfection tuberculosis among the school children; and then look at the very large cost of caring for a single case of reinfection type of pulmonary tuberculosis with the very long average duration from onset to recovery. I dare say, if one were actually able to put money-price on the social cost of each single case of pulmonary tuberculosis, and actually able to measure the relative hazard of school contact versus all the other contacts, and actually able to measure the increased incidence of tuberculosis from the presence of one tuberculous school employee, one would find $10,000 not too high a price to pay to catch the very last case of tuberculosis among the school employees—or even $20,000.

Stanford University Hospital.

THE X-RAYING OF SCHOOL PERSONNEL*

David T. Proctor, M. D.
Pasadena

TUBERCULOSIS case-finding surveys in the teacher and noncertificated school employee group have been slow in developing into full-scale projects. This type of survey is a natural outgrowth of examination of school children which has been going on for years. It would logically seem that both groups should be examined together and this has been tried, on the voluntary basis, and following preliminary education, in most instances. Because the results were so disappointing it has been necessary to make a separate drive and a different approach in the employee group. Where in students the response has been 70 per cent or better, that in personnel has been 50 per cent and below. This is a strong indictment against the method or the employee or both.

CONTACT GROUPS INVOLVED

We have learned from years of experience that the highest incidence of significant tuberculosis is in the adult group, and, even more, that reinfection tuberculosis is relatively uncommon in the grammar school child. Consequently, the school program is incomplete unless all the personnel have been x-rayed and certified free from active infectious tuberculosis. Unless 100 per cent are examined, the program is still incomplete; for the individual with active tuberculosis who fears losing his job may refuse to be x-rayed, and therefore may infect most of those in his room.

How then shall this group be approached? Will a better educational program be effective or will it be necessary to use compulsion? Although little has been written about it, there remains a definite impression that most tuberculosis associations and health departments feel that compulsion is necessary. This has been the definite experience of the Los Angeles County Tuberculosis Association for the past 12 to 15 years.

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* From the Los Angeles County Tuberculosis Association.

Read before the California Tuberculosis Association, Fresno, April 7, 1943.

PROCEDURES IN VARIOUS COMMUNITIES

The notable example of such a requirement on a state-wide basis is the State of Washington, where all private and public school personnel must be certified free from active tuberculosis. New York requires such certification as a prerequisite to a teaching license. California permits the local school board to pass such a ruling, but has not yet achieved the passage of a legislative statute. I cannot give the list but I understand that a number of other states are now demanding such certification.

The procedure is worthy of a little discussion because it is necessary to take into consideration the viewpoint of the individual, the organized teacher group as a whole, the private physician and the private roentgenologist. All such considerations must be secondary to that of public health welfare, so the procedure most acceptable is that one most efficient in discovering the most cases of tuberculosis. In evaluating efficiency of method there must be uniformity of technic.

In New York, the Health Department depends entirely on the x-ray which is taken and interpreted by its own staff. In Washington, the film may be taken by the private physician, but must be acceptable to and interpreted by a board of roentgenologists and phthisiologists appointed by the State Board of Health. For some years a negative tuberculin test, administered and read by the private physician was accepted, but this was found to be unsatisfactory so the method was changed.

In Los Angeles County each local school board has passed its own ruling requiring an x-ray of all its employees, then the County Health Department and County Tuberculosis Association combine facilities to provide the examination.

The statutory method of Washington caused a considerable furore among the teachers, particularly because they had to pay for it, but Doctor Soderstrom states in the March *National Tuberculosis Association Bulletin* that now the "campaign to protect school children from classroom exposure goes forward in harmony."

We have heard little complaint, and in some districts the teachers even voted to ask the school board to pass the ruling requiring such an examination. As the momentum increases, it will become easier and easier for other districts to install similar programs.

WHO SHOULD MAKE THE SURVEYS?

Private roentgenologists, individually and collectively, have from time to time voiced considerable objection to methods being used in making tuberculosis surveys. They feel that work is being taken from them by this use of Christmas Seal or tax money. It has been my experience that the private roentgenologist feels that he has not the time to have such survey groups running through his office, even if they could be taken away from work long enough to go there.

Survey and private x-ray costs are far apart; consequently the roentgenologist cannot afford to do much of this type of work under his present set-up.

The educational work and the cases found by tuberculosis association surveys certainly bring considerably more business to the private x-ray man. This is particularly true with the use of the new photoroentgen method.

In my opinion, the ideal way is for the tuberculosis association or health department to make the initial survey, in whatever group, then all follow-up or new employee films to be obtained privately. However, all certification should be in the hands of a board such as was established in the State of Washington. Tuberculosis workers are interested only in rooting out hidden cases of tuberculosis and will welcome assistance from any individual or group toward that end.

While it is true that exposing children to tuberculosis by even one teacher should be prevented, there are some qualified men who feel that survey money could be spent to much better advantage in other groups. Maybe we shouldn't spend any money on this group.

LOS ANGELES COUNTY STATISTICS

Consider a brief summary of statistics from the Los Angeles County Tuberculosis Association. In the years 1939-1942, inclusive, 5,526 school employees were x-rayed. Of these 122 or 2.2 per cent were diagnosed as having chronic pulmonary tuberculosis, and 12 or 0.2 per cent of the whole group as having clinically significant tuberculosis. Average age was 41. There was no significant difference between sexes or between certificated and noncertificated employees. The average age for certificated was 39, and for noncertificated 43, and, as would be expected, more tuberculosis was found in the older ages, incidence being about twice as high above 35 as below.

Edwards reports 1.0 per cent incidence of clinically significant tuberculosis, and 2.6 per cent total chronic tuberculosis in 3,185 New York teacher applicants with an average age of 29 years.

IN CONCLUSION

May I, in conclusion, humbly submit some opinions gleaned from over 3 years' close contact with school personnel surveys.

1. Tuberculosis surveys in this group are not profitable from the standpoint of clinically significant cases found as compared to other groups. So, if you are spending tax money and must show "pay dirt," go to some other group.

2. Children must be protected from tuberculosis contact, so school employees must be certified free from tuberculosis. Consequently, all should be x-rayed at least once and this will probably have to be underwritten by Christmas Seals.

3. Repeat examinations on those with negative films need not be oftener than every five years, unless clinical evidence to the contrary supervenes. These should be provided by the individual, or by the school board itself.

4. An applicant should be required to submit a diagnostic chest film with his credentials.

5. All films should be passed on by a board of experts appointed by the health officer.

6. Legislation, local school district or by state statute, is necessary to achieve this end, but the backing of organized teachers should be obtained, if possible.

7. In so far as possible, the private physician and private roentgenologist should be made a part of this program; but this desire must be subordinated to the need for uniformity and topnotch efficiency.

8. School employee surveys afford an excellent opportunity for educational work in a group capable of spreading far the truth about tuberculosis.

9. Follow-up of all chronic tuberculosis cases found should be closely supervised by the health department.

10. All reports should be kept confidential.

11. However, our main effort now should be in industry, and in high incidence groups, leaving the teachers for spare time and after the war.

65 North Madison Avenue.

TUBERCULOSIS AMONG STUDENT NURSES AND CONTACT EXAMINATIONS IN A GENERAL HOSPITAL*†

John B. Barnwell, M. D.

and

Jacob M. Beckerman, Dr. P. H.

Ann Arbor, Michigan

THE students who apply for nurses' training are the same age group as those who apply for entrance to the College of Literature and Arts at the University of Michigan. Yet we find five times more preëxisting pulmonary tuberculosis in the applicants to the nursing school than in the applicants to the College, but fewer student nurses react to tuberculin.

Only 38 per cent of the women on the campus finish the four-year college course, and only 48.7 per cent of the students finish three years' training in nursing. For reasons other than tuberculosis, the student nurses drop out at a fairly regular rate throughout the three years, except when a large number are dropped as scholastic failures at the end of the first semester. There are, then, a constantly diminishing number to be "exposed" to the one month's training on the Tuberculosis Unit, which comes some time in the last eighteen months of the three-year training period.

PERSONNEL EXAMINED

In the period of this study, January, 1932, to July, 1940, none of 611 nurses who started training came down with tuberculosis in the first year of training. For the rate of breakdown, or morbidity rate, in the second and third year of training, the statistical method of the "survival rate" of Frost[1] was suggested by Hilleboe.[2] Of 425 students who started the second year of training, six came down with tuberculosis and 98.4 per cent survived the full two years of training. Of the 312 students who started the third year of training, eight developed tuberculosis and 96 per cent survived the full three years of training. Thus, the loss in survival rate after the first year was gradual and showed no influence due to the specific exposure of the one-month tuberculosis training.

On entering training, 48.1 per cent of the student nurses gave no reaction to a strong tuberculin. Of these negative, 46.4 per cent remained negative throughout the course of training. By use of the "survival rate" for infection, as was done for disease, it was found that the rate of infection, or the survival from infection, progressed gradually through six-month periods with no sharp increases to indicate the influence of any particular service. At the end of the first six months of training, 96 per cent survived with negative tuberculins. At the end of the first eighteen months, 70.4 per cent survived or remained negative, while 46.4 per cent survived the three years' training.

A search of the records revealed only 90 student nurses who arrived at the tuberculosis service with negative tuberculins and with sufficiently clear tuberculin records to analyze the effect of the service on the conversion of negative to positive tuberculin reaction. Of this 90, there were 57 who were negative before the service, during the service and after the service. There were only three who were clearly negative before the service and who became positive after the service. The remaining 30 were negative before the service, but the subsequest tests were either not made or were made so long after the tuberculosis service that no conclusion could be drawn as to the effect of the service.

COMMENT

This evidence suggested that the tuberculosis service in this general hospital was not the only factor in the production of infection and disease among the student nurses, and perhaps was not even the major factor. The hospital records revealed that, from 1934 to 1940, the known cases of pulmonary tuberculosis were 2,932, and that only 54 per cent of these were treated on the two floors reserved for the tuberculous patients. It had further been found that 4 per cent of the sputum specimens found on the steps at the entrance to this general hospital contained acid-fast bacilli on direct smear.

REPORT ON A SPECIAL CASE

On July 17, 1938, the hospital admitted a student nurse whose case became of singular interest

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*A preliminary report read before the California Trudeau Society and the California Tuberculosis Association, Fresno, April 8, 1943. From the Tuberculosis Unit, Department of Internal Medicine, University of Michigan Hospital, Ann Arbor, Michigan.

† Statistical study aided in part by grants from the Horace H. Rackham and the Faculty Research Funds of the University of Michigan.

in the light it shed upon this problem. She had an acute cold with fever and a productive cough. The tuberculin and the sputum were found to be positive on admission, and the x-ray showed a moderately advanced cavernous tuberculosis confined to the left lower lobe. On February 18 of that year she had had a negative x-ray, and on April 21 her tuberculin had been negative. She had never served on the Tuberculosis Unit and the rapidity of the progress through first infection to reinfection and cavity was unusual. On questioning, she readily pointed out two patients she had attended on a general surgical ward, and on whom a diagnosis of pulmonary tuberculosis had been delayed.

One of these was a patient admitted as "Concussion? Brain tumor? Subdural hematoma." He was semi-comatose and went through several cranial trephinings. The nurses' notes contained frequent references to his cough and to the mucus that had to be wiped off his lips. Two months later the sputum was found to contain tubercle bacilli on the first examination. The x-ray showed unilateral cavity which should have been under treatment.

The other patient the student said she had nursed was admitted as "Ruptured appendix? and epilepsy." The patient knew that she had tuberculosis, but that part of the clinical picture was being ignored in the immediate interest of the appendiceal crisis and the frequent attacks of epilepsy. This patient remained in the surgical ward for seven weeks with no precautions taken toward sputum disposal, though the sputum was loaded with tubercle bacilli when it was first examined.

This situation presented an unusual opportunity for examination and follow-up of all the nurses who had attended these patients under circumstances where the duration and time of the contact was unusually well known. The hospital administration was asked to x-ray all these contacts at once and at three-month intervals for the next eighteen months.

From the nurses' notes it was found that 44 graduate nurses had made some report on service to these two patients. These 44 graduates reported a total of 530 such services to the two patients. Yet, of the 44 graduates only two were later diagnosed as having tuberculosis. Both of these had positive tuberculins before this contact, and by hindsight the beginning of the parenchymal involvement in the lung could be traced back to earlier x-rays.

By contrast, there were only 26 student nurses with reports of a total of 281 services to these two patients. Yet, four of the 26 students later came down with tuberculosis and all four had negative tuberculins before contact with these two patients. Only two of the four students had a service on the Tuberculosis Unit.

They came down in this order: First was the student who reported these two patients. She had moderately advanced cavity within 56 days of her first known contact. The second died of miliary tuberculosis 12 months after this first known contact, and six months after a one-month service on the Tuberculosis Unit. The relative influence of these two contacts is difficult to determine. This student was reported to the head nurse of the Tuberculosis Unit as being careless in her technique, and the student was assigned to no patients with positive sputum while on this service. The third student developed pleural effusion 19 months after this first known contact and eight months after the tuberculosis service; while the fourth student had pleurisy with effusion 24 months after the first but 21 months after her last contact with these two patients. All four of the diagnoses were proved bacteriologically by culture or animal inoculation. The average age of the 26 student nurses who attended these two patients was 20 years, while that of the 44 graduates was 26 years.

Later it was found that these two were not the only undiagnosed tuberculous patients on that general surgical ward. During most of June and July of 1938, it is now known that there were on a general surgical ward five open cases of tuberculosis, all being treated for other conditions and in ignorance of the complicating tuberculosis. The other three patients are of equal interest. One was diagnosed, on an x-ray from an outside laboratory before admission, as pulmonary abscess. The properly diagnosed abscess was drained but the first postoperative x-ray showed a tuberculous cavity in the opposite lung. Two sputum examinations on admission were negative, but three weeks later three examinations were all positive for tubercle bacilli. The second patient was admitted in extremis on a diagnosis of advanced bilateral bronchiectasis, properly substantiated on a previous admission two years earlier. The first x-ray on this admission showed tuberculous cavities in the upper lobes in addition to the lower lobe bronchiectasis, and the first sputum examined confirmed the diagnosis of tuberculosis. This patient lived in an oxygen tent and required eighteen tracheal catheterizations before her death a month later. Those nurses and others administering to her inside the oxygen tent were unaware of the tuberculosis.

The fifth case known to be on that ward during the same weeks presents a wholly different problem in the control of tuberculosis in a general hospital. He was admitted in December, 1937, with a diagnosis of intestinal obstruction. He also had a well-healed fibrous minimal tuberculous lesion of the lung shown on the x-ray, and the sputum culture was negative. It was thought it was perfectly safe to proceed with the indicated abdominal surgery. There were a series of operations, and each one was followed by some pulmonary complication, such as postoperative atelectasis on the side of the minimal lesion. The intestinal obstruction was never entirely corrected, and there was the additional factor of inadequate food intake. It is not just clear when in the course of his hospitalization this minimal lesion became reactivated, but by August, 1938, it was far advanced and the sputum was positive.

SUMMARY AND CONCLUSIONS

There appears to be more tuberculosis among our student nurses than among the same aged girl students in the college of literature and arts, and this is true of the applicants before they enter the hospital or the college.

No evidence was found that one month's training on a tuberculosis service was the only factor or even the major factor in the production of infection and disease among student nurses.

Tuberculosis, both known and unknown, is treated in other wards of the hospital. Serial examination of 26 student nurses contacting two unknown cases of tuberculosis discovered four who later developed tuberculosis. Two of these had had a month's tuberculosis service. Of 44 graduate nurses in contact with these two cases no effect could be traced to the contacts.

The cry has been raised, "Praise the Lord and x-ray all admissions." The attempt has been made, but cases are cited to show that no simple routine suffices to control the problem of tuberculosis in general hospitals. Constant and energetic clinical acuity is needed as well.

University Hospital.

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HEALTH IN THE AUXILIARY HOSPITAL WORKER*

Margaret Aldrich, M. D.
San Diego

THE city of San Diego has undergone an increase in population from 203,341, the official estimate of 1940, to 385,000, as estimated by OPA, January 1, 1943. This increase of 47.1 per cent has brought about problems in hospitalization as well as housing which have been met by:

1. Decreased number of hospital days per patient;
2. Increased bed capacity in private hospitals.

The increasing demands of the armed services for nurses and of defense plants for women war workers, the latter offering a higher rate of pay and more regular hours, plus the direct opportunity to serve one's country, has created a situation in which the hospitals are having difficulty in maintaining a minimum staff. This applies not so much to the graduate nurse as to those individuals classified variously as "ward attendants," "ward helpers," "paid aides," and "subsidiary workers."

PERSONNEL GROUPS

The need for increased personnel has been met differently in individual hospitals: by increased number of graduates, increased nursing school enrollment, employment and training of groups of older women for attendant service, use of Red Cross nurses' aides, and employment of untrained women who are trained as they work in some particular department. Since we are interested in the health of these auxiliary workers, we ask, "What plan has been made by the hospital to assure that the worker is employable, and to protect the worker in case of accident or illness?" A survey of five hospitals in San Diego has revealed that the health examination and the health hospital service offered varies with the institution and with the type of auxiliary worker as follows:

1. *Ward Helpers.*—The hospital employing the above has increased its bed capacity from 115 to 165 beds, with an average daily census of 153.2. The increased need for help was, prior to September, 1942, taken care of, but unsatisfactorily, by the use of untrained girls, the majority of high school age. They received no physical examination prior to employment and were covered by workman's compensation insurance. The failure of the plan to produce a reliable, useful worker became apparent and was discontinued, to be replaced by one consisting of the training of groups of mature women in the fundamentals of patient care, with special training under the direction of the supervisor of the specified department.

These employees may have complete physical examinations with x-ray and laboratory work, as indicated by members of the hospital's "Health Committee," but such an examination is not compulsory. All are covered by workmen's compensation, which in this particular instance takes care only of compensation for time lost; the responsibility for the actual care in case of accident being assumed by the hospital.

Ward helpers are eligible for enrollment in the Associated Hospital Service, a voluntary plan, the members of which receive the medical services of the staff doctors and hospitalization through benefits of their insurance.

2. *Red Cross Nurses' Aides.*—These are voluntary workers trained by the Red Cross, with the coöperation of the Class A hospitals in the community in which they receive their training. Applicants are accepted only after having passed successfully a physical examination, including vaccination for smallpox and immunization for typhoid (if advised by the physician). Although the routine examination does not require an x-ray of the chest, except as indicated, all aides of the San Diego hospitals, thus far, have had chest x-rays at their own expense, arranged for by the examining physician.

On completion of the eighty-hour course, the aides are required to give 150 hours of voluntary service per year if they are to continue as active members of the Corps. This service is to be on wards exclusive of contagion, venereal disease, tuberculosis and isolation units in pediatrics. Furthermore, aides are instructed not to work if ill.

The Red Cross originally planned that each hospital should assume responsibility in case of injury, but it was not until February of this year that the Nurses' Aide Committees were notified that members of the Association of California Hospitals must carry workmen's insurance for volunteer nurses' aides.

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* From the Vauclain Home, San Diego.

Read before the California Tuberculosis Association, Fresno, April 8, 1943, in the symposium on "Health of Auxiliary Hospital Workers."

Since part of the original plan of the Red Cross is that nurses' aides should be used by the office of Civilian Defense, they must register with the ODC and are protected by insurance as are other members of that personnel, to cover any injury incurred during an emergency. All hospitals accepting the services of nurses' aides offer first aid for injury sustained in line of duty, but since they cannot be classified as employees they are ineligible for hospitalization insurance.

3. *Paid Aides.*—An increase in average daily census from 287 to 365 in a period of two years was noted in San Diego's largest private hospital. This increase is in part taken care of by the employment of paid aides, women who are instructed as they work, by the supervising nurses. In the event that their duties include food handling, they are required to have the routine food-handler's examination. No preëmployment examination is offered or required, principally because of the rapid turnover occurring in this group.

4. *Ward Attendants.*—The San Diego County General Hospital has, with increased employment in the city and county, reduced the number of available beds by ninety-three, with an increase of average daily census from 421.99 to 471.53. This apparent discrepancy is due in part to increased daily census in the tuberculosis division of the San Diego County General Hospital, plus the admission of private patients for emergency care when beds in private hospitals were not available. Prior to December 31, 1942, the hospital was supplied with WPA workers, but since this project has been discontinued we find an increase in the number of ward attendants, employees who have had no previous training. These employees are protected by workmen's compensation and are eligible, if they so desire, for group hospitalization insurance. No preëmployment examination is required, except for those working in the tuberculosis unit, all of whom are given an initial chest x-ray, followed by fluoroscopic examinations every three months. In the event that such employees are given a permanent rating, they will receive, at the request of the Civil Service Commission, a physical examination which does not include, unless indicated, an x-ray of the chest.

SUMMARY

The results of such a survey may be summarized as follows:

(*a*) Total increase of 150 beds in three San Diego hospitals. The need for additional personnel, supplied through the use of ward helpers, Red Cross nurses' aides, paid aides, and ward attendants.

(*b*) Lack of routine preëmployment examination for all auxiliary workers, exclusive of nurse's aides, due primarily to rapid turnover of employees in this classification.

(*c*) Failure of those examinations which are available to include a specific examination for the exclusion of tuberculosis.

(*d*) Conflicting opinions of hospital heads as to liability for volunteer workers.

Vauclain Home.

HEALTH IN THE AUXILIARY SANATORIUM WORKER*

Mary Rust Gruetzman, R. N.
San Jose

THE Medical Director of the Santa Clara County Sanatorium has often said that it is safer to work in a sanatorium than in the average general hospital if you wish to avoid having tuberculosis. When the students of our hospital begin their work in the sanatorium, Doctor Ianne, in his first lecture, quotes the following from an article by Meta Bean in the *National Tuberculosis Association Bulletin* of June, 1938: "Almost two-thirds as many Wisconsin patients died from tuberculosis in general hospitals last year (1937) as in sanatoria."

It is my experience that many people, both professional and nonprofessional, hesitate to expose themselves to tuberculosis in a sanatorium. This attitude has been expressed through the heads of national organizations. The directors of the WPA were unwilling to assume the responsibility of women on their projects working with an infectious disease. Today there are about 60,000 intelligent women who have received their certificates as voluntary Red Cross auxiliary workers, and are assisting with the care of patients in both civilian and federal hospitals. This well-organized program consists of eighty hours of practice and theory. The training and qualifications of these women are of a higher standard than the average aide who is employed in our sanatoria today. Reports of their work are most favorable. The Red Cross, however, stipulates that these aides are not permitted to care for an infectious disease, because they believe these workers have not obtained sufficient knowledge to protect themselves. Since all employment is becoming increasingly difficult, and the choice of aides more limited, the objection to working with tuberculosis is more evident, and the need for aides in local institutions and Army hospitals is growing daily.

The aides employed in our institution are usually chosen from the middle-age group who often apply for work because of economic difficulties in the home or because of age discrimination in other occupations. These women who have been good housekeepers and intelligent mothers have developed an understanding of life which helps them to adapt themselves to the routine. However, at this age, as was discovered with the older men in the armed forces, the physical defects and mental adjustments cause considerable inconvenience.

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* From the Santa Clara County Hospital, San Jose.

Read before the California Tuberculosis Association, Fresno, April 8, 1943, in the symposium on "Health of Auxiliary Hospital Workers."

All new employees in our institution are given a physical examination, which includes routine laboratory, x-ray and tuberculin test. We have the straight eight-hour work-day, and forty-eight hours per week.

These women are not expected to assume responsibility for giving medication or treatment to the patients. Their work consists entirely of bedside care, bathing the patient and making him comfortable, and household duties. The aides are taught a modified isolation technique for their protection, and also the sputum technique practiced by the patient, which is most important for the workers. The mask is worn when working with very ill or uncoöperative patients. Nourishment, in the form of milk, oranges and graham crackers, is served to all employees between 10 and 11 each morning. Every effort is made to safeguard the aides and keep them as happy as possible. They receive $95 or $100 per month, plus three meals and laundry.

Many surveys have been made showing the frequence with which students and graduate nurses become infected with tuberculosis. During my thirteen years in the sanatorium we have had 22 graduate nurses, 10 student nurses, and 12 aides as patients. None had gotten their infections through contact in a sanatorium. All infections had come through general hospitals. Of 89 students who had a twelve weeks' training with us, 17 were admitted with negative tuberculin; 7 became positive and 10 remained negative. One student who was negative throughout her sanatorium course became positive three months later, while working in the out-patient department of the general hospital.

SANTA CLARA COUNTY EXPERIENCES

Some facts concerning our own institution may be interesting. Conversations with doctors and nurses who have known the Santa Clara County Sanatorium since 1910 give the following information:

1. The institution had its beginning in the primitive tent style.

2. No student, graduate nurse or other employee is known to have had active tuberculosis through contact in this sanatorium, despite the following facts:

(*a*) There were few, if any proper facilities for using good technique at that time.

(*b*) The working hours were long.

(*c*) The majority of patients had far-advanced tuberculosis.

(*d*) The young student was sent to care for these far-advanced tuberculous patients without being taught how to protect her health. A supervising nurse states that as late as 1927, the technique of sputum disposal was most inadequate. When she first entered upon her new duties she found sputum cups left carelessly on window sills, on shelves and in odd corners.

(*e*) There was no educational program for the patient, which is one of the chief essentials in health protection.

(*f*) Disposal tissues were probably unknown.

If it is true, as Doctor Plunkett has told us, that "tuberculosis is the unexploded bomb which follows war," then this must be the opportune time to dispel some of the fear-complex about tuberculosis.

Santa Clara County Hospital.

TUBERCULOSIS OF THE AUXILIARY HOSPITAL WORKER *

Mary E. Jordan, R. N.
San Leandro

Much publicity has recently been given to "absenteeism" from war work, emphasis being placed on trying to find a solution to this waste in manpower. This appeal has especial significance for hospitals, since we are not only engaged in a vital war work, but are having increased difficulty in adequately staffing our institutions. Obviously we should consider by every possible means the health of each employee.

AUXILIARY WORKER GROUP

My understanding of "Auxiliary Worker," as the term is used at Fairmont Hospital, applies to the nonprofessional group which assists in the care of patients in the hospital. They may be classified according to the degree of contact with tuberculosis patients: (1) Attendants and orderlies.; (2) Ward porters and maids; (3) Diet maids. I am confining my remarks to the "Attendant" group. Registered nurses available for civilian hospitals continue to be reduced, and hospitals not having schools of nursing must depend more on this auxiliary group of workers to assist in the care of patients. The importance of some type of health program should be recognized to prevent the worker from losing time through illness which is the cause of most of their "absenteeism." These health measures not only prevent loss of time, but also give the medical and professional nursing staff an opportunity to teach workers their own responsibility for health, and the benefits derived from such a program. A genuine pride may be developed in not "losing time"; some employees, in fact, being reluctant to go "off duty" even when advised to do so by the physician.

TRAINED ATTENDANTS

To supplement the work of registered nurses at Fairmont, a hospital for the care of chronic and convalescent patients, it has been necessary and desirable to use trained attendants. For many years we have conducted a thirteen months' organized course of instruction for nursing attendants. Our permanent attendants have been selected from the group who have had the course. There has been developed a health program for all employees which, in the main, has been satisfactory. Since it is somewhat intensified with this group, it begins with their preacceptance physical examination.

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* From the Fairmont Hospital, San Leandro.
Read before the California Tuberculosis Association, Fresno, April 8, 1943, in the symposium on "Health of Auxiliary Hospital Workers."

which is checked by Fairmont Medical staff upon entrance, and continues through the term of employment. The actual examination includes laboratory reports, fluoroscopic and x-ray of chest, and graduated doses of tuberculin.

PROCEDURE WITH EMPLOYEES

Upon employment, each employee has a chart consisting of the initial physical blank, laboratory report, doctor's order sheet, and progress sheet. These charts are kept in locked files and are available only to the supervising nurse and medical staff. An employees' clinic is held at 7:30 a. m. daily; to conserve the time of the medical staff an effort is made to adhere to this hour. Before going to the clinic, each employee must secure a request, signed by department head, asking the physician to see the employee. The findings and orders are entered on employee's chart, and the printed form is returned by employee to department head with the diagnosis and recommendation. This gives the department head the opportunity to follow up to see that the recommendations are properly carried out. The medical staff determines the employee's fitness for work. For emergencies, including accidents occurring on duty, an employee receives medical attention immediately. A record of any accident which employee might sustain, if of a minor nature, is made by employee himself. These forms, 3 x 5, are filed by each department head, and if something later develops which would be compensable, the record is available. In a large organization, much of the doctor's time may be conserved, since some minor accidents do not require medical attention. At the beginning of the calendar year, each employee is reëxamined, including a fluoroscopy of chest. Each person is advised of any future medical attention indicated. Fluoroscopy or x-ray of chest may be made at any time, since there is a tuberculosis service in connection with the institution.

INSTRUCTION COURSES

Since much of the routine bedside nursing care is given by student attendants, organized classroom instruction is started the day they enter. The ethical aspect of care of their health is pointed out by explaining to them the nature of the work and that during their course definite important tasks are expected of each one. They are given several hours' instruction in personal hygiene, which includes characteristics of a healthy individual, importance of an annual physical examination, essentials of health, importance of posture and exercise, need of proper recreation, and adequate rest and food habits.

Since the student attendants have as a part of their experience an assignment on the Tuberculosis Service, it is necessary that they be given instruction in aseptic or isolation technique used at this hospital. They are not assigned to these wards, however, until they have had this instruction and have been in the school several months. They have a fluoroscopy of chest at completion of the course.

Several lectures on tuberculosis are given, one by a physician. These include: brief history of tuberculosis, types, modes of transmission, symptoms, curative aids, precaution, care of hemorrhage cases. Since the student attendants are required to do much of the bedside nursing, they should receive as much protection as possible, and should be required to adhere to the same technique as that used by the professional group performing the same duties: use of gowns, masks, and special emphasis in washing of the hands.

EDUCATION OF THE PATIENTS

The education of the patient is an important factor in preventing the transmission of disease and must not be overlooked. On admission, a printed folder is given the patient, and it is the responsibility of the supervisor to acquaint the patient with each item. This includes an explanation of the nature and treatment of tuberculosis, and the regulations of the hospital. In some instances the student attendants have been apprehensive about caring for tuberculous patients; that fear has been largely overcome with instruction.

Since the course for attendants was started at the Fairmont Hospital in 1929, more than 500 students have entered, and about 400 have completed the thirteen months' course, each student having had from eight to twelve weeks' duty in the tuberculosis service. Our records show that two students developed the disease during their course. and two others who continued on as permanent employees later developed it. Our small percentage of student attendants contracting the disease, however, compares favorably with studies made in schools of nursing. To quote from an article written by H. McLeod Riggins, M. D., and J. Burns Amberson, Jr., M. D., Bellevue Hospital, New York City, published in the October, 1940, issue of *The American Journal of Nursing,* entitled "The Detection and Control of Tuberculosis Among Nurses": ". . . based on an average of 207 student nurses in the school. This represents an average of 1.93 nurses per 100 nurses per year."

IN CONCLUSION

Factors complicating the situation are:

1. The supervising nurse, burdened with routine ward duties, has little time for proper supervision of workers.

2. The education of patients may be neglected.

3. Workers are more easily fatigued, due to war conditions; increased home responsibilities, or difficult transportation facilities.

4. Inadequate and less efficient personnel may result in technique being carelessly performed, thus increasing hazard to employee.

In view of war conditions, it is more imperative than ever that an adequate program for health conservation and protection of all employees should be developed and maintained.

Fairmont Hospital.

Marin.—The Marin County Association owns its own fluoroscope and carries on its work in coöperation with the County Health Unit. Tuberculin testing of school children is also a part of the work of the Association.

This year an effort is to be made to have culinary workers and teachers fluoroscoped.

TUBERCULIN PATCH: ITS EVALUATION IN A SURVEY OF 4,429 SAN JOSE HIGH SCHOOL STUDENTS*

Lydia L. Verbarg, M. D.
San Jose

Ever since Vollmer and Goldberger in 1937 introduced the patch test in the form of an application to the skin of filter-paper squares soaked with pure O. T. as a test of tuberculin sensitivity, both physicians and the lay public have been extremely interested in the use of this form of tuberculin test. Vollmer and Goldberger, along with other workers, have been convinced of the reliability and maximum effectiveness of this test. Others have had more doubtful results, so that no uniformity of opinion exists as to the worth of the tuberculin patch test alone as a means of detecting the tuberculin reactor.

COMMENT ON THE LITERATURE

A brief review of the literature since 1937 shows how divided is opinion on this matter:

Vollmer and Goldberger[1] themselves in 1937 described the patch test and compared its value with that of the well-known Pirquet test. Both tests were done on a group of 209 tuberculous children. They showed conformity in 187 or 89.5 per cent, and nonconformity in 22 or 10.5 per cent, of which 15 reacted to the patch and not to the Pirquet test.

In the following year these same authors[2] published observations on patch tests done on 169 tuberculous children. The patch test used was one employing tuberculin approximately four times stronger than that originally used. The results were compared with the Mantoux intracutaneous test using PPD. Only one child failed to react to the patch test who, at the same time, reacted to the intracutaneous test.

In 1941, Smith, Fulkner and Cordi[3] reported "the tuberculin patch test was positive in 113 (97 per cent) of 116 children who reacted to 0.1 mg. or less of O. T. by the intradermal method." Further, they state "no correlation between tuberculin sensitivity and degree of infection was apparent."

In a subsequent study of 417 unselected children, Goldberger and Vollmer[4] reported the reliability of the patch test as compared with the Mantoux test using 0.1 mg. of old tuberculin to be practically 100 per cent; only four results showed lack of conformity and, of these, three were reactors to the patch test.

Fineman and Bair[5] in 1940 reported on a series of 330 patients who were tested by both the Pirquet and patch tests, and also were examined with the Mantoux test whenever the Pirquet tests were negative. They found 43 of the group reacted to the Pirquet test, 54 reacted to the patch test and 17 of the nonreactors to the Pirquet test reacted to the Mantoux test. They agreed that 95 per cent of this tested group had corresponding reactions with both the Pirquet test and the patch test, but 5 per cent of this group disagreed, of which 14 were positive patch and negative Pirquet. The patch test agreed in 97 per cent and disagreed in only 3 per cent. Their conclusions were that the patch test was more sensitive than the Pirquet and less sensitive than the Mantoux test.

In 1941, Crumm, Cookson and Broadbent,[6] reported on 1,556 high school freshmen tested with the Vollmer and PPD tests, and x-rayed. They used one-fifth dose of second strength PPD and found a 98 per cent correlation between the patch test and the PPD.

In 1937, Wolff and Hurwitz[7] reported on a series of 1,075 tests in which the Mantoux test using 0.1 mg. O. T. was employed at the same time the patch test was applied. The agreement was 98.2 per cent. In 1.3 per cent the patch was negative and Mantoux positive. In 0.5 per cent there was a positive patch and negative Mantoux reaction.

Peter Cohen[8] of Santa Barbara, in an article on the tuberculin patch test, concluded that the Vollmer-Lederle patch test agreed in 99 per cent of those tested with the Mantoux test, using PPD first and second strength. The patch test gave a positive reaction in 11 individuals negative to the Mantoux test, while the Mantoux test resulted in a positive reaction in 4 persons who were negative to the patch test. He concludes that the patch test is recommended as a first step in case-finding in tuberculosis.

In contradiction to these favorable findings, there are reported in the recent literature several discrepancies:

In 1938, 613 students[9] of the Stuyvesant High School were tested with the patch test and with PPD intermediate strength (5:10,000 or 0.1 mg. O. T.). Eighteen had a reaction to the intradermal test and not to the patch, and 4 had a reaction to the patch and not to the intradermal.

Peck and Wegman,[10] in 1939, found even a larger discrepancy. They reported 28.3 per cent difference between the patch and PPD first strength and 70.5 per cent between the patch and PPD second strength. Their tests were done on a group of 880 rural school children. In numbers they found the patch test positive on 94 children, PPD first strength positive on 131 children, and PPD first and second strength positive on 319 of the children. They concluded that the patch test is useful only as a first test. In February, 1940, Hughes reported on a series of 100 tuberculin sensitive patients, whom he had tested with the patch test and with PPD first and second strength. Of 100 reactors to PPD second strength, 78 reacted to PPD first strength (all of these patch reactors) and 89 reacted to the patch test—11 more than reacted to PPD first strength. He concluded that the patch is more sensitive than PPD first strength, but less sensitive than PPD second strength.

In the study made of the comparative value of the Mantoux and patch test in the New York Institute for Education of the Blind, in 1938 and 1940, Kereszturi[11] found that of 379 tested, 83 reacted to both tests, while 31 reacted only to the Mantoux test and 28 reacted only to the patch test. She concluded that "The tuberculin patch test has a limited field of usefulness, and cannot replace the Mantoux test."

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* From the San Jose Public Schools, San Jose.
Read before the California Tuberculosis Association, Fresno, April 7, 1943.

A very interesting report on the quantitative studies of the tuberculin reaction with reference to the patch test may be noted:

This report by Furcolow and Robinson[12] appeared in *Public Health Reports* of December 19, 1941. Their conclusions were that the reaction to the patch test varied as the tuberculin sensitivity of the individual: the more sensitive the individual, the greater his likelihood of reacting to the patch test; and that the more potent patch will detect the most reactors. In their study 1.0 per cent PPD patch was more potent than either the O. T. or the 0.1 per cent PPD patches. These last two they considered of about equal strength. They further decided that the site of application of the patch seemed to have little relation to the efficiency of the test. They say: "If it is accepted that reactors to 1/10,000 mg. or less of PPD include most of all persons whom it is desirable to detect in a routine survey, the patch test as used in these studies will detect such persons with an error of about 6 per cent 'missed' and 7 per cent 'extra' reactors."

COMMENT

A great deal of confusion seems to exist in the literature in that no uniform patch test has been used in the comparison of the patch test with known, standardized strengths of tuberculin as used in the Mantoux test. Some have used the Vollmer test as put out by Lederle, some the Wolff test as put out by Eli Lilly, and some have referred to a patch test using a PPD material for the test material in the patch.

Since no one uniform patch material has been used in the various group tests, nor material of comparable tuberculin content has been applied, it seems almost valueless to try to compare the results of one worker with those of another.

SAN JOSE PUBLIC SCHOOLS: PROCEDURES USED

In our San Jose public schools, with a student population of about 11,000, we had for several years been tuberculin-testing the high school children with PPD second strength only. There were several reasons for the feeling at that time that only one test should be used rather than using the two tests of the two strengths of PPD when indicated. The physician-time available was limited, children often refused a second intradermal test because of fear of the "needle," and the problem of a third visit by the doctor to test the absentees who had already had a negative PPD first strength became a burden. However, when three years ago we had, out of a group of 789 children tested, 12 youngsters with marked reactions to the PPD second strength, reactions which included systemic reactions of malaise and fever, axillary lymph node swelling, large local area of redness, and induration and blistering, and red streaks up the lymph channels of the arm, we decided that some sort of first test had become necessary. In 1940, in testing the children of the junior high schools and one of the senior high schools, we applied simultaneously homemade patch tests and the intradermal test, using PPD second strength. The patch test material was that supplied by Eli Lilly and Company for the Wolff percutaneous test. Two patches of hypoallergic adhesive tape, about 1½ inches square, were prepared for each child. On one patch was applied a small drop of the test material. On the other patch was applied a small drop of the control material. The skin of the under surface of each arm was wiped with ether and the patch with test material placed on the left arm, that with control material on the right arm. The PPD second strength 0.1 c.c. was placed intracutaneously on the flexor surface of the left forearm, after wiping the skin with alcohol.

The children were all supplied with written instructions advising them that it was important that the adhesive patches stay on a full 48 hours, that they were not to go swimming, nor to take a shower, nor to allow the patches to get wet, and that if the patches became loose, to return to the nurse who would refasten the patch. At the end of the 48 hours, the intradermal tests were read and the adhesive patches were removed. In this way, we had some control over knowing how many patches apparently stayed on the full two days. The patch tests were read in 96 hours.

The results of these tests were as follows: Of 789 students tested, 111 or 14.2 per cent reacted to both the intradermal and the patch test. Thirty or 3.8 per cent had negative patch tests, though they reacted to the intradermal test, while only 2 or 0.25 per cent reacted to the patch test and not the intradermal test. At the Technical High School, of 66 tested only 9 or 13.8 per cent reacted to both tests, while 10 or 15.4 per cent reacted to the intradermal test only, and none reacted to the patch test only. These tests were carried out under most optimum conditions for group testing in that we felt we did have the coöperation of the students who took the test, and that they conscientiously tried to keep the patches on for the full 48 hours. We were exceedingly careful, too, in reading these tests and in trying to evaluate the reactions without prejudice, by reading the patch test first before glancing at the forearm at the site of the intradermal test.

From our results of that one year's experiment we learned several lessons. We learned that homemade patch tests take too much time to prepare when a large group of children are to be tested. We learned that a number of our objectors to the tuberculin test were no longer objectors if the patch test were used in place of the intradermal test, and we learned that children of high school and junior high school age can and will coöperate in keeping patch tests on the proper length of time if they understand the importance of the request. Before each tuberculin testing season, each grade of students to be tested are assembled for a talk by one of the school physicians, or by one of the physicians doing chest work in our city. At these talks, we stress, along with the importance of the tuberculin test and the reason for having every child tested, the various ways of doing the tuberculin test. At this point we explain that a patch test will be used as a first test, and stress the importance of the child assuming his responsibility in carrying out this test properly. At the time of the test, each child is handed a sheet of paper on which has been mimeographed the following: "Your adhesive patch should stay on for 48 hours (2 days). Then remove it yourself and throw it away. If it loosens before it should come off, fasten it on with another piece of adhesive tape. Do not wash or rub it off in the showers. Come back to this office in four days to have the doctor see your arm. Do not go in swimming until the patch is to come off."

Then, of course, from our first small experiment we found that we ourselves could not be satisfied in using the patch test as the only means of detecting our tuberculin reactors, but that it was a very satisfactory means of eliminating a large group of reactors painlessly, and in eliminating, we hoped, all those who would react with undesirable local and systemic reactions to the intradermal test. We have never had systemic reactions to the patch test. We have had no violent reactors to the PPD second strength in those negative to the patch test. Those of you who work with children who have parents not always of the understanding type know how much this can mean.

TABLE 1—*Statistics for Different Years*

	No. Tested	Patch	%	PPD	%	Total	%
1940	789 Jr. High	83	10.5	30	3.8	113	14.3
1941	1,048 Jr. High	87	8.3	77	7.3	164	15.6
	283 Sr. High	12	4.2	26	9.2	38	13.4
1942	783 Jr. High	56	7.2	35	4.5	91	11.6
First Test	1,057	31	2.9	48	4.6	79	7.5
Retest	469 Sr. High	5	1.1	15	3.2	20	4.3
Totals All Years, All Groups	4,429	274	6.2	231	5.2	505	11.4

FINANCIAL COSTS

Before undertaking to establish the patch test as a routine test, now that we knew it had really desirable features, we met up with the one big factor in its disfavor—that of increased cost. PPD material costs approximately $2.50 for 100 tests given, plus the cost of the tuberculin luers, needles, and alcohol lamp if the flaming method of sterilizing the needle is used. The prepared patch tests, of which the Lederle-Vollmer seemed to be the only one available at the time, cost six cents a patch in lots of less than one thousand, and four cents a patch in lots of one thousand or more. If less than one thousand tests are done, the patch tests then cost about twice that of the intradermal test. We decided in favor of the patch test in spite of this added expense, because of all the other desirable features of the test.

OTHER STATISTICS

So the next year (1941), the patch test was done routinely on all not previously tested and to be tested this year. In the junior high schools, a total of 1,048 children were tested. Of these, 87 or 8.3 per cent reacted to the patch test and 77 or 7.3 per cent of the nonpatch test reactors reacted to the PPD second strength intradermal test. This was a total of 165 or 15.6 per cent reactors in this group. In the senior high schools, the students were divided into two groups—those who had never before been tested and those who had been previously tested, but were not previous reactors. Of the first test group, we had 283 tested this year. Twelve or 4.2 per cent of these reacted to the patch test, and 26 or 9.2 per cent of the nonreactors to the patch test reacted to the second strength PPD intradermal test. This yielded a total of 38 or 13.4 per cent reactors in this group. We tested the 1,066 previous negative reactors with the second strength PPD intradermal only, that year, so that we cannot give patch figures for that group; but, as a matter of comparison and interest, we will mention that 56 or 5.3 per cent of this group were reactors to the PPD second strength.

We have no statistics as to the length of time that had elapsed between this test and the previous tests. The time interval, however, was at least one year in all cases.

TABLE 2.—*Other Statistics*

	Total Number	Positive %	Positive No.	Patch %	Pos. Patch No.	but Failure %
1940 Using Wolff Percutaneous Patch Test Material	113	100	83	73.4	30	26.6
1941 Using Lederle-Vollmer Prepared Patches	202	100	99	49	103	51
1942 Using Lederle-Vollmer Prepared Patches	190	100	92	48.4	98	51.6
Total 1941 and 1942 based on Lederle-Vollmer Prepared Patches	392	100	191	48.7	201	51.3

This past year of 1942, there were tested 783 junior high school students of whom 56 or 7.2 per cent reacted to the patch test, and 35 or 4.5 per cent of the nonreactors to the patch test reacted to PPD second strength intradermal test, giving a total of 91 or 11.6 per cent reactors in this group. In the senior high schools a total of 1,057 students were tested for the first time, of which 31 or 2.9 per cent reacted to the patch test and 48 or 4.6 per cent reactors to the patch test reacted to PPD second strength intradermal, a total of 79 or 7.5 per cent reactors in this group. Among those students who had previously had a tuberculin test but had not reacted, 469 were tested. Of these, 5 or 1.1 per cent reacted to the patch test, and 15 or 13.2 per cent nonreactors to the patch test reacted to PPD second strength intradermal, a total of 20 or 4.3 per cent reactors in this group. Again we know only that this group had had previous tests some time one year or longer previously.

If we consider all reactors as 100 per cent, and consider by percentage the fraction not discovered by the patch test but discovered by the PPD second strength intradermal test, or patch test failures, we have a comparison as indicated in Table 2.

IN CONCLUSION

We have separated the results of the Wolff percutaneous patch tests from those of the Vollmer test, not for the purpose of comparing the two tests, but simply because different materials were used. Our conclusions are that the patch test, as a means of finding tuberculin reactors among school children, is a highly desirable form of "first test," since it eliminates the use of one of two intradermal tests—in themselves disadvantageous because of the fear of the child of the "needle," and because of the remote but possible chance of infection. The patch test has an added advantage in not necessitating physician-time in its application, since it can easily be applied by the nurse or by any responsible person. However, because of the 25 to 50 per cent failure of the patch test to pick out reactors to tuberculin, it can be used only as a "first test" and should never be relied upon wholly as a means of finding the tuberculin reacting individual. It is to be urged that widespread effort should be given to instructing the medical profession against using only the patch test as the means of finding the tuberculin reactor.

408 Almaden Avenue.

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PATCH TEST: ITS EVALUATION *

Gordon A. Diddy, M. D.
San Jose

In the N. T. A. *Bulletin* of March, 1940, Dr. Hermann Vollmer stated: "Case finding means the discovery of persons with tuberculous lesions not yet arrested, rather than finding of positive reactors to tuberculin." I would reword this statement by saying: "Case finding means the discovery of persons with unknown tuberculous lesions regardless of status (active, quiescent or arrested); that the most fruitful method of discovering active cases or spreaders of disease is by tuberculin-testing our school children and completing the family follow-up on all contacts to reactors."

As you can judge from Doctor Verbarg's discussion of the literature, there are many conflicting reports regarding the efficiency of the patch test versus the Mantoux test. Early reports were more enthusiastic about the patch test than are more recent reports. Early use of the patch test was in cases of clinical or known active tuberculosis. In such cases the test was 99+ per cent as reliable as the O. T. or PPD intracutaneous tests. Three years ago we tested our patients in the Santa Clara County Sanatorium with both patch test and 1:10,000 O. T., and found the conformity of the two to be 98.8 per cent. There were 129 persons who were tested.

It has since been generally shown that the patch test is not as efficient as the Mantoux in persons with a low sensitivity to tuberculin. Most recent reports have concluded that the patch is as efficient as PPD first strength, and is a satisfactory screening first test; but all negatives should be retested with PPD second strength. This is the conclusion reached from the study of the two tests in the San Jose schools.

It seems to me that Doctors Vollmer and Goldberger,[1] two of the most ardent supporters of patch-testing, have delegated the patch test to its proper place when they state: "It seems that the Mantoux with 0.1 mg. O. T. or less, or with first strength solution of PPD can be replaced by the tuberculin patch test. A routine is suggested for tuberculin testing, the tuberculin patch test being proposed as the first test."

There are some who are advocating routine fluoroscopy or fluorography of all school children without tuberculin testing. This type of program is better than nothing, but it is quite inadequate when you consider that fluoroscopy or even x-ray exam-

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* Read before the California Tuberculosis Association, Fresno, April 7, 1943.

ination in school children will reveal on the average from .2 to 1 per cent positive chests, while tuberculin testing will reveal an average of from 10 to 25 per cent reactors, thus giving a much larger field for case finding or search for spreaders of disease. There is no doubt but that routine fluoroscopy, fluorography, or x-ray have their place in case finding among adults, especially in our armed service, industry and the general hospital clinics. There can also be no doubt but that the most adequate case-finding program in our schools depends upon screening the reactors, x-raying some and making a complete follow-up of the families to locate the spreaders.

In Santa Clara County, from May, 1940, to May, 1942, 533 x-rays were taken on contacts to reactors in school surveys. Among this group 32 active or suspicious cases were found. Of these only two persons or .3 per cent were in the age group under 18; 6.4 per cent were 18 or over. The discovery of these 32 cases represents the fruit of our school survey and family follow-up.

Santa Clara County Hospital.

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COMMUNITY EXPERIENCE*

Robert S. Quinn, M. D.
Santa Rosa

THE war has not confronted us with the tremendous case-finding problems created by the influx of persons into communities in which there are large war industries.

Rather, it is our problem to continue intensifying the program of tuberculosis control among our somewhat stable population.

Sonoma County is a comparatively rural community with a population of 70,000 in the 1940 census. It is probable there has been an increase of five thousand since the onset of the war. The northern portion of the county is mainly agricultural. Here we are confronted with a transient population in the fruit-picking season. The southern part of the county is confined largely to dairying and the poultry industry. In this area we find a rather stable population.

SONOMA COUNTY ENVIRONMENT

There are six incorporated communities in the county. Santa Rosa, in which the Sanatorium is located, is near the center of the county, and is surrounded by the other communities at a distance of from seven to twenty miles. It is this central location of Santa Rosa upon which our entire program is based.

We have another asset in what we are pleased to call a "unified" Health Department. By that I mean that the medical and health set-up are under the direction of one person who is Director of Health of this unified system, and who is also our acting health officer for the duration. By having this unified system we are able to coördinate our case-finding programs in the acute hospital and its out-patient clinics; the Health Department and its various clinics with the tuberculosis hospital and its case-finding projects. In the present set-up we have two assistant health officers, one of whom is in charge of venereal disease control throughout the county, and the other is in charge of the entire tuberculosis program. Our five public health nurses work in the various clinics, under the direction of the three health officers. Consequently, they have first-hand information of the persons attending the clinics, and therefore receive complete instructions on the procedure to follow regarding the care and follow-up of any given patient.

RÔLE OF SONOMA TUBERCULOSIS ASSOCIATION

Our Tuberculosis Association is dovetailed into the program very closely, and it is consulted or directed, as the case may be, regarding all problems in tuberculosis control that arise throughout the county.

Originally, all of our work was done through a biweekly diagnostic and follow-up clinic held at the Sanatorium. Discharged sanatorium patients, contacts, and known arrested cases of tuberculosis were followed in these clinics. It was necessary for patients or children with positive skin tests and their families in all parts of the county to go to the clinics in Santa Rosa. But war made it necessary for us to alter this situation. Consequently, last summer the Tuberculosis Association provided us with a portable fluoroscope. Clinics are still continued at the Sanatorium for the follow-up of our out-patients and for those persons in the Santa Rosa area. We have added to this schedule a fluoroscopic clinic one night each month in the major communities. These clinics have only recently been established; they are entirely voluntary and are arranged by the executive secretary of the Tuberculosis Association. A skin-testing program is continued, not because of the number of cases of tuberculosis found, but rather because the opportunity is maintained to get literature and our public health nurses into many homes. We also skin-test all prenatal cases, as well as all children admitted to our pediatric wards.

We are coöperating closely with the Medical Corps of the induction center of the United States Army. Information is reported regarding possible cases of tuberculosis in any inductee from our county. These persons are promptly contacted by our health nurses and brought into our clinics. Through this method we have seen several persons with evidence of arrested disease. These we continue to follow in our clinics. From this source we have found three cases of active pulmonary tuberculosis.

Following the recent fluoroscopic survey at the Basalt Rock Company in Napa County, we were given forty-one names of workers residing in our county; twenty-six of these had reference to their lungs. From this list we have hospitalized two cases of active disease.

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* From Oak Knoll Sanatorium, Santa Rosa.

Synopsis of a paper read before the California Trudeau Society and the California Tuberculosis Association, Fresno, April 7, 1943, in symposium on "War-Time Tuberculosis Case Finding."

Since September, 1942, we have fluoroscoped 650 high school seniors. Fifteen x-rays were ordered. One case of active tuberculosis was hospitalized and two cases of suspected tuberculosis are now under close observation. We have fluoroscoped 550 adults. Ten x-rays were ordered. One case of active tuberculosis was hospitalized and two cases of suspected tuberculosis are under close observation. The statistics given do not include the 3,000 fluoroscopies done in the Sanatorium clinics. I believe that the persons seen with our portable unit would not have responded had it been necessary for them to come to Santa Rosa. This year we have done 2,502 skin tests on children in the kindergarten, first, fourth, seventh, and ninth grades, and all new students. These do not include any who had positive skin tests in previous years. Out of this group we found 207 positive reactors, all of whom, with as many of their contacts as we could induce to come to the clinics, were fluoroscoped.

RECENT ADMISSIONS TO OAK KNOLL SANATORIUM

Nearly all of our recent admissions to the Sanatorium are men. This is probably due to the fact that when the men, as heads of families, are receiving large wages they are able to provide private care for their dependents. If, on the other hand, the men develop tuberculosis, their income ceases immediately and they are forced to enter the county institution.

At the present time the majority of cases of active tuberculosis are being found from one of the following three sources: (1) Those admitted to the acute hospital and diagnosed after having been admitted for some other complaint. (2) Those persons who voluntarily present themselves at our clinics for examination. (3) Those cases that are picked up by our doctors in private practice. Most of the doctors in our county are now skin-testing and fluoroscoping the patients coming into their offices.

WORK AMONG CIVILIANS

Our immediate problem is how to reach the small groups of employees found in the dairies, chicken ranches, and other minor industries. We plan to purchase a trailer in which we can set up our fluoroscope in a dark room, have some small dressing cubicles, and a desk for a secretary. This trailer could be driven to any one of these plants at any time and the entire personnel examined. This would be done only after the proper groundwork had been laid by the Tuberculosis Association. We plan to go with our fluoroscope into the larger industries as soon as permission can be obtained.

Up to the present we have not been able to satisfactorily solve the problem of the defense workers living in our county and working elsewhere. These persons are scattered throughout every town and many are living in trailer camps. Over and above that, they work very irregular hours. All of this results in a poor response to any voluntary plan for fluoroscoping these persons. I would like to suggest that perhaps the best way for these persons to be surveyed would be in the large industries in their respective counties, following the lead of the Basalt Rock Company. The entire plant personnel could be fluoroscoped. If the results were given officials in the home county of the employees, all contacts and suspicious persons could be followed. There is one loophole in this scheme. Several persons, when told to see their private physician following the Basalt survey, did not appear. When attempts were made to contact them they had already left their jobs and moved out of the county. Probably these persons previously knew they had tuberculosis and, since jobs are plentiful, merely moved to another community in order that their condition might not be suspected. This would occur in a very small percentage of cases.

Finally, there is the question of our transient population who work in the fruit industry for three or four months each year. We are at a loss to know how to properly solve this problem with them.

IN CONCLUSION

The battle against tuberculosis in Sonoma County was started in earnest on January 1, 1938, with the establishment of a full-time health department. At that time the death rate was given as 72 per 100,000. At the end of the fiscal year, 1942, however, our death rate was computed to be 33.7 per 100,000.

Sonoma County Hospital.

THE CYSTIC LUNG*

Louis J. Ruschin, M. D.
San Leandro

THERE is no unanimity of opinion regarding the etiologic factor in certain pulmonary cystic structures. This is due to the fact that more than one factor may operate in several instances of pulmonary cystic structures.

An etiologic classification of pulmonary cystic cavernous structures is submitted, but only those disorders about which there is no unanimity of opinion will be discussed, namely, true congenital pulmonary cysts, emphysema, and acute localized emphysematous bullae.

TRUE CONGENITAL CYSTIC LUNG

The greatest variance of opinion exists concerning the occurrence and frequency of congenital cystic lung. Pierce and Dirkse[1] considered true congenital cysts in adults to be rare, and believed that the assumption of the congenital nature was too often founded upon insufficient evidence—due to inadequate antecedent history, and incomplete evaluation of respiratory diseases by the physician.

PATHOGENESIS

Heuter,[2] in 1914, believed that pulmonary cysts developed as a result of stenosis of bronchial branches, and he sponsored the term "congenital bronchiectasis" as von Grawitz[3] had in 1880. S. Smith,[4] in 1925, postulated the theory of an embryonic defect in the development of a bronchus. Mueller,[5] in a critical review of the pathogenetic theories prior to 1928, was of the opinion that a bronchiolar bud becomes arrested in its growth before it attains the stage of a hollow tube, and that, at some subsequent date, the terminal part begins to grow and forms a closed sac into which fluid is secreted by the lining epithelial cells.

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* From the Fairmont Hospital, San Leandro.

Read before the California Trudeau Society at Fresno, April 8, 1943.

Simpkins[6] stated that the bronchi develop as small ramifications of entodermal tissue which becomes canalized directly. Crosswell and King,[7] and Harris,[8] believed that an unknown process interferes with this canalization at some point proximal to the termination of that ramification, with the resultant occlusion at that point. Beyond this point canalization continues, and an isolated canalized segment is formed. The mucous membrane of this segment assumes a normal function, and a cyst is formed. The rate of prenatal growth and the size of the cyst at birth depend on the amount of functioning bronchial mucosa entrapped and the capsular strength of the cyst.

Anspach and Wolman[9] believed that the cysts begin as fluid-containing cavities, either single or multiple. If bronchial communication does not occur, the cysts remain fluid-filled. If communication does occur, air will enter the cavity and the degree of expansion will depend upon the character of the communication and the capsular strength of the cyst. Jackson[10] described types of bronchial obstruction represented in mechanics by: (1) stop valve; (2) check valve; and (3) by-pass valve. Autopsy records of Nelson[11] and of Jacobs[12] demonstrated the check-valve type in expansile pulmonary cysts, and the autopsy reports of R. T. Miller[13] and of Hennell[14] revealed the by-pass type of valve in nonexpansile pulmonary cysts.

PATHOLOGY

The diagnostic confirmation of the condition depends on the histopathologic examination of the cystic structures in the lung. The occurrence of pulmonary cysts in the stillborn and in the newborn, as proved by autopsy, is probably the strongest evidence in favor of the congenital nature of the disorder.[15] Infection may destroy the typical histologic picture.

The number and distribution of the cysts vary a great deal. Schenck,[16] in a survey of 374 cases, found 141 solitary cyst cases, and 233 multiple cyst cases. The survey revealed 21 per cent bilateral cases, 42 per cent right lung involvement, and 37 per cent left lung involvement.

A connection between the cyst and the bronchial tree may be demonstrated. Diamond and Durham[17] noted instances in which lipiodol failed to enter the cystic structures, and suggested that minute openings, or none at all, explain that phenomenon. Noncommunicating cysts are complete in themselves, as demonstrated at autopsy.[3, 18] Stewart, Kennedy, and James,[19] by careful reconstruction of cysts in the wax model, demonstrated that the majority of cysts communicated with the bronchial tree, and that only a small number were true cysts.

TABLE 1.—*Classification of Pulmonary Cystic Structures*

I—TRUE CONGENITAL PULMONARY CYSTS.

- Solitary } Fluid   Limited expansibility
- Multiple } Air } Expansile (check valve)
-   Both } Non-expansile (by-pass valve)

II—ACQUIRED CYSTIC STRUCTURES

- a—Aberant germ cells
    - 1. Dermoid and teratoma
- b—Parasitic
    - 1—Hydatid
- c—Degenerative
    - 1—Chronic emphysema { Blebs (interstitial) / Bullae (vesicular)
    - 2—Neoplasms
- d—Inflammatory
    - 1—Bronchiolectatic (honeycomb)
    - 2—Bronchiectatic
    - 3—Pyogenic (epithelialized abscess)
    - 4—Tuberculous (necrosis)
    - 5—Coccidioides
- e—Mixed (inflammatory, developmental, mechanical, degenerative)
    - 1—Acute localized emphysema
    - 2—Tuberculous tension cavities
- f—Developmental
    - 1—Pulmonary hypoplasia

III—NON-RESPIRATORY PULMONARY CYSTIC STRUCTURES

- a—Eventrations and diaphragmatic hernia

The lining of the cysts varies from a high columnar to a cuboidal or flattened epithelium.[18] In the absence of an epithelial lining, a vascular granulation tissue is found.[18, 20] The wall of the cyst lined with epithelium usually shows structures commonly seen in the wall of the bronchi and bronchioles.[21]

The fluid cysts contain a gelatinous, limpid fluid, comparable to egg-white, free of fat, but high in albumin content.[22] Fibrous strands may traverse the cysts, and give the appearance of trabeculations.[21-a]

SYMPTOMS AND DIAGNOSIS

The clinical symptoms vary markedly, and depend largely on the number, size, and location of the cysts, the presence or absence of bronchial communication, the expansile or nonexpansile nature of the cysts, and the presence or absence of infection at the moment, or in the antecedent history. The frequency of the more common symptoms, as compended by Schenck,[16] are: cough, dyspnea, expectoration, cyanosis, fever, hemoptysis, malnutrition, thoracic pain, weakness, anorexia, wheezing, vomiting, palpitation, and epigastric distress. All or part of these symptoms may be present, depending upon the factors outlined above. Also, the clinical symptoms may be nil.[23] Asthmatoid symptoms may be prominent. Emphysema[24] and cor pulmonale contribute their share of the symptomatology. Spontaneous pneumothorax has been recorded in cases of congenital cystic lung.[14, 25]

The diagnosis of congenital pulmonary cysts is not easily established with certainty in the clinical patient. The roentgenogram is usually suggestive. Lipiodol bronchograms are not invariably valuable or conclusive.[17] Bronchoscopy is of little diagnostic value except in a negative sense. Physical findings are extremely variable and are not pathognomonic.[18] The diagnosis of congenital pulmonary cysts must be made with proper appreciation of their infrequency in comparison with the acquired varieties.

TREATMENT

The treatment of the true congenital cyst is medical or surgical, depending on the nature of the case. Lung cyst emptying and closing are rare in the literature.[8, 25] Asymptomatic fluid cysts have been recorded.[27] Single or multiple, noninfected, nonexpansile cysts in the asymptomatic state may be treated in an hygienic, prophylactic manner. When a multiplicity of cysts involves the lungs bilaterally, surgery usually is impossible. The prevention of the development of an emphysematous state which would further contribute to the symptomatology should be attempted. Should the involvement be unilateral, lobectomy or pneumonectomy is possible. Removal of expansile cysts *in toto* is eminently successful in selected cases.[28, 29] Thoracentesis of balloon (expansile) cysts is indicated for the relief of acute symptoms.[8, 26-b]

The deflation should not be accomplished in a rapid manner. Cysts of the lung which have become infected will rarely be cured without complete removal or destruction of the secreting lining of the cavity.[15, 29] Maier and Haight [30] emphasized the importance of biopsy in cases thought to be chronic empyema.

EMPHYSEMA

That emphysema is a degenerative lesion of the lung is open to debate by the purist. However, it may lead to the formation of large cavernous areas which simulate cysts.

Emphysema may be defined as an overdistention or overinflation of the lung. Overdistention occurs in the inflated lungs during a forceful expiratory effort, when the escape of air is retarded by a closed glottis or bronchial stenotic process. Unequal compression in different portions of the lung allows a local overdistention. Overinflation occurs when portions of the lung are in a nonexpansile condition (fibrotic or atelectatic), and the thoracic cage enlarges to the same degree as in health. The expansile portions of the lung compensate for the nonexpansile by an increase in volume. Overinflation is favored by insufficient expiration, due to loss of lung elasticity and chest-wall elasticity, which accompanies age. The lungs are insufficiently emptied and the inspiratory effort is increased to establish the proper proportion of residual air to tidal air, and to facilitate gaseous exchange. This may progress until the mechanical state of fullest inspiration prevails.

Repeated and prolonged overdistention and overinflation of alveoli lead to destruction of capillary loops in the walls and to atrophy of the walls. Repair and restoration to a normal state are impossible. This local atrophy may progress to the formation of bullae.

W. S. Miller [31] stated that bullae are formed by the distention of the alveoli themselves, and the larger bullae are the result of rupture of the alveolar walls and fusion of the dilated spaces. He stated that blebs are formed by the escape of air into the interstitial tissues of the lung, and localization of air in the areolar connective tissue of the pleura.

Miller suspected that these loculated emphysematous lesions might cause annular shadows in the roentgenogram. Laurell [32] pointed out the importance of localized obstructive emphysema in the production of pulmonary cavities surrounded by annular shadows (of atelectatic lung). Doub [33] reported the first American cases in which autopsy demonstrated pulmonary blebs and bullae in areas corresponding to cavernous annular shadows in the roentgenogram.

TREATMENT

The treatment of emphysema has not been entirely satisfactory. Prophylactic measures are most important when applicable. A relatively small amount of normal lung tissue suffices for the breathing needs of a healthy individual except under stress. Haldane [34] stated that about one-tenth of the total lung tissue will provide for the gaseous exchange needs under resting condition. Emphysema without fibrosis is encountered rarely. Most sufferers with pulmonary emphysema would survive in comparative comfort if their chest could diminish in size to conform to the diminished lung capacity occasioned by fibrosis, instead of having the remaining lung tissue undergo emphysematous change to conform to the chest capacity. Possibly surgical measures with the aid of bronchial spirometry will offer a solution to this problem. Rebreathing exercises, abdominal belts, and pneumoperitoneum have been employed to advantage in selected cases.

ACUTE LOCALIZED EMPHYSEMA

Acute respiratory tract infections are a potent cause of acute localized emphysema. Certain infections exhibit a toxic or trophic disturbance, even distant from the seat of infection, which results in a weakening of the alveolar walls and elastic tissue. Should a severe cough complicate such an infection, the increase in intrapulmonary air pressure facilitates emphysema in these weakened areas. The presence of bronchitic and bronchiolitic inflammatory states may produce a valve action which increases the bullous formation. The inflammatory residua in these bronchi and bronchioles may perpetuate the bullous state long after the acute inflammatory state has disappeared. That bronchi dilate during inspiration, and contract during expiration, has been observed and adequately substantiated. This phenomenon may allow the bronchial inflammatory residua to function as a check valve. Caffey [35] stated that the rapid dilatation and contraction (sometimes followed by reexpansion and recontraction) of pulmonary cystic structures in acute respiratory disorders furnish strong presumptive evidence that inflationary forces are more important than the destructive agents in their genesis. He emphasized the fact that air-fluid levels in pulmonary cavities are not pathognomonic of lung abscess. Cheney and Garland[36] pointed out that serial roentgenograms of patients recovering from various inflammatory diseases of the lungs, particularly pneumonia, have disclosed an astonishingly large number of bizarre cyst-like lesions. Although most of these lesions remained unchanged, some disappeared spontaneously and some increased in size.

Zarfl,[26-c] in 1933, applied the term *pneumatocele* to this local acute emphysema. Pierce and Dirkse,[1] in 1937, made similar observations, and applied the term *pneumatocele*. Cheney and Garland[36] suggested the term *pneumocele*. The phenomenon is an expression of local acute emphysema.

The above phenomenon has long been observed in tuberculous lungs and contributes no small number of the tension cavities of tuberculous lungs. That emphysematous bullae may be mistaken on the roentgenogram for tuberculous cavities has been demonstrated at autopsy.[37]

The symptomatology of this group of cases is identical with that discussed under congenital cysts. Many of these cystic structures disappear following the subsidence of the precipitating factors. For this reason, the diagnosis of lung abscess should be made only after due consideration of all the anatomical-etiological possibilities.

TREATMENT

Some of these cystic structures persist for months, or apparently permanently. These cases must be individualized in making therapeutic recommendations. The symptomatology, the size, the number, and the reinfection of the locale are determining factors. The main perpetuating factors may frequently reside in the draining bronchiole as a check valve. Complete patency of the bronchiole, or the obliteration of the bronchiole allows for collapse of the bulla, the first by elimination of the check valve which maintains an intrabulla pressure positive in relation to the atmospheric pressure, and the second by absorption of the entrapped air. Transpleural catheter cavernous decompression[38] may be of some value in selected cases after pleural fusion. Bronchoscopic therapeutic approach may prove of value in some instances.

SUMMARY

The etiologic factors and the pathogenesis of congenital cystic lung, chronic emphysematous bulla, and acute localized emphysematous bulla have been discussed. Therapeutic considerations and approaches have been suggested.

A great variety of lung abnormalities and disorders have been lumped together under the one term "cystic lung." While it undoubtedly is true that a number of cases reported are of congenital origin, recent observations seem to indicate that the number is much smaller than was formerly thought. Numerous persons born with apparently normal lungs develop pulmonary cystic cavernous structures later in life. A careful history and repeated examinations over a long period of time often suggest the pathogenesis of acquired pulmonary cavernous structures in individual patients. In at least an equal number, however, exhaustive studies are of no avail, and the etiology remains obscure.

Fairmont Hospital.

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THE CYSTIC LUNG*

J. J. Singer, M. D.
Los Angeles

The paper of Doctor Ruschin covers the subject of the cystic lung from various standpoints. The different types of cysts, that is, the true congenital, the hydatid cyst, and the acquired cyst, each represent a different type and can be differentiated by a careful history, and particularly by x-ray studies.

The use of iodized oil applied into the bronchus, or directly by a puncture of the chest wall, has furnished considerable information as to the character of the cysts, and also their extent. In the ordinary film of the chest, the fine walls of the cyst are frequently not visualized, but when the films are taken tangentially, complete outlines are frequently observed.

In children, and occasionally in adults, the large balloon cysts are taken for spontaneous pneumothoraces, and the use of iodized oil in this type is particularly valuable.

Another method to determine which is a cyst, and which pneumothorax, is to insert a needle connected with a manometer; if one obtains the usual variations, a little air is introduced into the space. One can then see whether he is in the pleural space or a cyst. I have seen three cases in which iodized oil was put into the pleural space which produced a symphysis of the pleural sheets so that spontaneous pneumothorax could not develop when the cyst ruptures.

Patients may live a long time with cysts, but when they are infected it becomes a surgical problem.

In the emphysematous type, one can see the size of the cyst enlarge from month to month and from year to year. This rarely happens in the congenital type. In one case that I have observed in a man in the eighties with severe dyspnea, the diagnosis of pulmonary cyst was made, when the patient died suddenly, a small carcinoma was found at the end of the bronchus which partially blocked the bronchus and the large cyst developed. At the postmortem the lung looked like a large balloon; a slight nick with the knife and the walls of the cyst collapsed.

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* From the University of Southern California School of Medicine.

Discussion given before the California Trudeau Society, Fresno, April 8, 1943.

The treatment of the acquired cysts of the lung is nonsurgical, and symptomatic—that is, by restricted activities and attention to the general health. The hydatid form of cyst is rare in this country, and is almost always connected with liver echinococcus.

2208 West Third Street.

LUNG FLUKES[*]

Lt. Comdr. John Miller, M. C., U. S. N. R.
Oakland

THE lung fluke, or paragonomous Westermanni, is endemic in the South Pacific Islands. It has a complicated life cycle; but, human in section, is mostly crab or crayfish. Direct transfer of its section is possible. Differential diagnosis from other tropical diseases is necessary. There may be thoracic, abdominal, or granular symptoms.

Brown flecks in a very tenacious sputum is suggestive. The eggs are found in fresh unstained sputum. X-ray examination of the chest may well be negative.

The lung fluke infection should be suspected in any patient from the South Pacific who has chronic bronchial disease; secondly, a peculiar type of chest pain, or thrombophlebitis.

The diagnosis is essentially a laboratory procedure and depends upon finding the typical egg under the microscope.

Oak Knoll Hospital.

WHAT IS HAPPENING TO THE YOUTH OF TODAY?[†]

C. Morley Sellery, M. D.
Los Angeles

THE paradox of youth inspired to new heights of patriotism, willingness to serve, desire to attain skills which will best serve in our war effort, and youth neglected at home, breaking away from school to work at wages which they are too inexperienced to know how to spend prudently, seeking excitement and unhindered by any mature judgment or guidance, paints an alarming picture in the paper.

The breaking down of the home life, the inadequacy of health agencies because of lowered budgets and depleted personnel requirements, the increase of juvenile delinquency, are all brought to the forefront of attention.

Youth will do its part in the war effort, says the author, but will adults do their part in keeping the good that has been in the world to help make this the kind of world the youth are struggling to build?

Chamber of Commerce Building.

WHAT IS HAPPENING TO THE YOUTH OF TODAY?[*]

C. F. Perrott
Turlock

THE speaker made his discussion of the topic under four headings: Awareness of the interdependence of all countries of the world; suppression of social menaces; home teaching of basic moral truths; and adherence by adults to laws for spiritual growth. Youth will meet the problems presented to it by the war, said the speaker; they are patriotic, earnest and enthusiastic, but they still look to the adults for leadership. Like others discussing the subject, the speaker ends with a question: "How well are we adults doing?"

Turlock Union High School.

WHAT IS HAPPENING TO THE YOUTH OF TODAY?[†]

Walter H. Brown, M. D.
Berkeley

I FIND myself in complete agreement with the deep concern with reference to the signs of increased delinquency, inadequate provision for wholesome recreation and the apparent disintegration of family. Surely all of these are danger signals and demand action. They should result in social action.

However, in spite of all of the unavoidable tragedy of war, one can detect unmistakable signs that many youths are finding themselves with a purpose so high and holy that they are willing and eager to fight or even die for it. This has nothing to do with whether they are rich or poor, educated, or ignorant. It is the inherent soundness of the majority of youth who have grown up under our American way of life, many of whom are already proving their essential worth in every part of the globe.

It seems to me that our obligation, as adults, is the need to so live and act that we will be worthy of the sacrifices that youth is making in our behalf.

University of California.

CHILDREN IN WAR WORKERS' HOMES[‡]

Elizabeth Hall
San Francisco

THE paper discusses the basic needs of children, which are the same, war or no war: good health, security and opportunity for development.

It further discusses what California is doing to meet the basic needs of children. War has made meeting this need more difficult, and, according to statements from heads of the official agencies responsible for the children of the State, the effort has not been successful.

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[*] Synopsis of a paper read before the California Trudeau Society, Fresno, April 8, 1943.

The opinions and assertions contained herein are the private ones of the writer and are not to be used as official or reflecting the view of the Naval Department or the naval service at large.

[†] Synopsis of a paper read before the California Tuberculosis Association, Fresno, April 7, 1943.

[*] Synopsis of a paper read before the California Tuberculosis Association, Fresno, April 8, 1943.

Copy of complete paper may be secured from the California Tuberculosis Association.

[†] From the University of California, Berkeley.

Synopsis of a paper read before the California Tuberculosis Association, Fresno, April 7, 1943.

[‡] Synopsis of a paper read before the California Tuberculosis Association, Fresno, April 8, 1943.

Copy of the complete paper may be secured from the California Tuberculosis Association.

The subject of housing, child care centers, recreation facilities, and public health facilities are discussed, with statements of facts as shown in official reports. Figures and facts from reports of the Children's Bureau, U. S. Public Health Service, U. S. Housing Authority and others are also quoted.

Particular reference is made to the subject of day-care of preschool children.

45 Second Street.

THE TREATMENT OF SYMPTOMLESS SURVEY TUBERCULOSIS *

Sidney J. Shipman, M. D.
San Francisco

THE members of the panel agreed that x-ray surveys of the chest are extremely valuable in finding pulmonary abnormalities, many of which are tuberculous. Further study was necessary in most cases to establish the etiology of the lesion, and if it were tuberculosis, whether or not if be active.

It was apparent that all discussants were in complete agreement to the extent that survey cases deserve individual treatment after a more or less complete clinical check-up.

It was the consensus of opinion that many would require only periodic observation by some form of x-ray examination, particularly in the presence of symptoms, while others would need sanatorium care or compression therapy.

It was agreed that asymptomatic cases were perhaps the most difficult to judge, and that the observation period in these cases might require several months. The point emphasized by each discussant was that perhaps the majority need not have their lives or their work too drastically altered, but that some modification of their mode of living might be sufficient to enable them to maintain health and well-being and make them safe members of the community.

490 Post Street.

HEALTH EDUCATION IN THE SCHOOL SYSTEM†

Joseph Burton Vasche
Modesto

UNDER ten headings, the speaker covered the theory and practice of health teaching in the schools. Under ten other headings he covered the health education activities which might be carried on coöperatively by schools and the Tuberculosis Association or other health agency.

These twenty points were documented, to show actual health education programs now under way, with items of the programs and how they are administered.

Stanislaus County Schools.

HEALTH EDUCATION IN INDUSTRY*

Bernice Frankenheimer
Stockton

THE speaker related how the local Tuberculosis Association had arranged for and carried on a health education project among industries. The manner of making initial contacts, with management and labor leaders, materials used, and ways of approach, were used to illustrate the theory that Tuberculosis Associations have a definite place in industrial health programs.

130 South American Street.

HEALTH EDUCATION OF THE COMMUNITY AT LARGE†

Mabel Morrison
Ukiah

THE speaker reviewed the procedure used in educating people in Mendocino County to the need of surveys to find tuberculosis. The originating of the plan, the publicity, the materials for use in the surveys, and the results of the campaign, were outlined.

624 South State Street.

State Bureau Chief Talks on Plans and Problems.—A plan for x-raying the chests of all inmates and employees of State penal and charitable institutions was outlined by Dr. Edward J. Kupka, Director of the Bureau of Tuberculosis of the State Department of Public Health, at the recent meetings of the Tuberculosis Association secretaries held in Los Angeles and San Francisco.

"There are between 30,000 and 40,000 inmates and approximately 10,000 employees in these twenty-one institutions," Doctor Kupka said. "In one ward of an institution in which patients were x-rayed, one patient in seven was found to have tuberculosis. While this percentage probably will not hold when all patients are examined, it definitely proves that a great deal of tuberculosis exists in these institutions." . . .

"The State tuberculosis control office has existed for more that twenty-five years, and in the early days the Department worked hard encouraging the building of sanatoria. Today extra beds are needed in only a few places in California. The Department also inaugurated case-finding and was the first organization in the State to examine apparently healthy people for tuberculosis. This function has been taken over by the local agencies, as it should be.

"The Bureau of Tuberculosis is not an operating agency," Doctor Kupka declared. "The work of health education of the public needs the services of experts in that field, and we look to the voluntary agencies to carry on this work although the State will continue to do some educational work among physicians.

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* Synopsis of a paper read before the California Trudeau Society, Fresno, April 7, 1943. Panel Discussion: John B. Barnwell, Ann Arbor, Michigan; Philip H. Pierson, San Francisco; Howard W. Bosworth, Los Angeles; and Carl R. Howson, Los Angeles.

† Synopsis of a paper read before the California Tuberculosis Association, Fresno, April 8, 1943.

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TUBERCULOSIS ORGANIZATIONS IN AMERICA

The National Tuberculosis Association was organized in 1904 for the purpose of "studying tuberculosis and spreading knowledge as to its causes, treatment and prevention." The National Association is the nominal head of more than 2,000 local groups which carry on work in all forty-eight states, in Alaska, Hawaii and Puerto Rico.

Each of these associations studies the problem in its own area and working with the medical societies, and the public health agencies, has moved toward the final eradication of tuberculosis.

The work of the tuberculosis associations in America is supported by the annual sale of Christmas Seals which, in 1942, provided more than eight million dollars. (The 1943 Christmas Seals, designed by Andre Dugo, go on sale November 22.)

* * *

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3937 Orange Street, Riverside
N. O. Norsworthy, President
Mrs. Louise W. Phillips, Executive Secretary

Sacramento County Tuberculosis Association
1006 Seventh Street, Sacramento
Fontaine Johnson, President
Laurence R. Kirk, Executive Secretary

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Hollister
Eleanor Nolan, PHN, President

San Bernardino County Tuberculosis Association
490 Court Street, San Bernardino
J. Clifford Lee, President
Mrs. Bertha V. Peterson, Executive Secretary

San Diego Tuberculosis Association
Community Welfare Bldg., Room 2
1266 Seventh Avenue, San Diego
Mrs. Francis H. Mead, President
Mrs. Jessie S. Ward, Executive Secretary

San Francisco Tuberculosis Association
604 Mission Street, San Francisco
Easton G. Hecker, President
Paul Neiman, Executive Secretary

San Joaquin County Tuberculosis and Health Association
130 South American Street, Stockton
Mrs. Percy T. Cleghorn, President
Miss Bernice Frankenheimer, Executive Secretary

San Luis Obispo County Tuberculosis Association
Atascadero
Mrs. A. S. Young, President

San Mateo County Tuberculosis and Health Association
115 South Ellsworth Avenue, San Mateo
Bradford M. Melvin, President
Mrs. Ruth Close, Executive Secretary

Santa Barbara County Tuberculosis and Health Association
23 La Arcada Building, Santa Barbara
Frank J. McCoy, President
Graydon Dorseh, Executive Secretary

Santa Clara County Tuberculosis Association
409 Beans Building, San Jose
J. C. Cuneo, M. D., President
Mrs. Ann Castellanos, Executive Secretary

Santa Cruz County Tuberculosis and Health Association
21 Front Street, Santa Cruz
Peter Jansse, President
Mrs. B. B. Wilder, Executive Secretary

Shasta County Tuberculosis Association
Redding
C. C. Gerrard, M. D., President

Sierra County Tuberculosis Association
Loyalton
Hollis Snell, M. D., President

Siskiyou County Tuberculosis Association
Yreka
O. G. Steele, President

Solano County Tuberculosis Association
228 Napa Road, Vallejo
Gordon C. Bunny, M. D., President
Mrs. Dalrie Lichtenstiger, Executive Secretary

Sonoma County Tuberculosis Association
618 Fourth Street, Santa Rosa
C. M. Carlson, M. D., President
William M. Flaherty, Executive Secretary

South Pasadena Tuberculosis Association
1132 Mission Street, South Pasadena
Mrs. Joie C. Tunison, President

Stanislaus County Tuberculosis and Health Association
Turlock
C. F. Perrott, President

Sutter County Tuberculosis Association
Yuba City
Mrs. A. D. Atterbury, President

Tehama County Tuberculosis Association
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Bert Storm, President

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Mrs. Julia Dimond, Executive Secretary

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Sonora
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455 East Main Street, Ventura
Mrs. Roger Edwards, President
Mrs. J. D. Woods, Executive Secretary

Yolo County Tuberculosis Association
Woodland
Mrs. Douglas McWilliam, President

Yuba County Tuberculosis Association
309 C Street, Marysville
J. W. Linstrum, M. D., President

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION[†]

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PHILIP K. GILMAN, M. D.	Council Chairman
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OFFICIAL NOTICES

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred and Eleventh (311th) Meeting of the Council of the California Medical Association*

The meeting was called to order in Room 210 of the Hotel Sir Francis Drake, in San Francisco, at 10:30 a. m., on Saturday, June 19, 1943.

1. Roll Call:

Councilors present: Philip K. Gilman, Chairman; Karl L. Schaupp, Lowell S. Goin, William R. Molony, Sr.; E. Vincent Askey, E. Earl Moody, Dewey R. Powell, Sam J. McClendon, Calvert L. Emmons, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and Secretary George H. Kress.

Councilors absent: Edward B. Dewey (ill), Edwin L. Bruck (out of city), and Donald Cass (excused).

Present by invitation: L. A. Alesen, Vice-Speaker; Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; Mr. John Hunton, Executive Secretary; Mr. Hartley F. Peart, Legal Counsel; Mr. George Smith, Associate; Mr. Ben Read, Secretary, California Public Health League; Representatives of the San Diego County Medical Society: (W. H. Geistweit, Jr.; Edward A. Blondin, and Bryant R. Simpson); Representatives of the Solano County Medical Society: (Carl A. Snoddy, F. Burton Jones, and Howard R. Madeley); Representatives of the Federal Public Housing Authority: (Mr. Langdon W. Post, Mr. William Reidy, and Mrs. Marion Beers Howden); and Representatives of California Physicians' Service: T. Henshaw Kelly, and Alson R. Kilgore, members of Board of Trustees, and A. E. Larsen, Secretary).

2. Minutes:

Minutes of the following meetings of the Council were submitted and approved:

(*a*) Los Angeles Council Meeting (306th) held on February 28, 1943. (Abstract printed in CALIFORNIA AND WESTERN MEDICINE, April, 1943, on pages 236-240.)

(*b*) Los Angeles Council Meetings (307th, 308th, 309th, and 310th), held on May 1, May 2, May 3, and May 3, respectively. (Printed in CALIFORNIA AND WESTERN MEDICINE, June, 1943, on pages 366-369.)

3. Membership:

(*a*) A report of membership as of June 17, 1943, was submitted and placed on file.

(*b*) On motion duly made and seconded, it was voted that 136 members whose membership had automatically lapsed on April 1, because of nonpayment of dues, but whose dues had been paid since the last Council meeting, held on May 1, 1943, be reinstated.

(*c*) Upon motion duly made and seconded, Retired Membership was granted to the following member whose application had been received in duly accredited form from his respective county society:

Walter B. Coffey, *San Francisco County.*

4. Financial:

(*a*) A report of finances as of June 17, 1943, was submitted and placed on file.

[†] For complete roster of officers, see advertising pages 2, 4, and 6.

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

(*b*) Report was made that the notes covering amounts due the California Medical Association from California Physicians' Service had been brought into proper legal form as per House of Delegates resolution (Reference No. 31 on page 357 of June CALIFORNIA AND WESTERN MEDICINE, in minutes of House of Delegates.)*

(*c*) On motion duly made and seconded, it was voted that annual dues for the calendar year 1944 be the same as in 1943, namely, twenty dollars.

(*d*) Physicians' Benevolence Fund:

It was voted that the amendment passed by the House of Delegates on May 3, 1943, allocating $1.00 per active member as per House of Delegates Resolution (Reference No. 39), became effective on May 3, 1943, and that such allocation should be made for the current calendar year.

It was agreed that the allocation of $1.00 per active member so made should only apply to those active members whose dues were received through their respective county societies, and should not apply to active members in military service whose dues are covered by allotment from the General Funds of the Association.

Because of the passage of the new amendment, it was voted that the allotment of $5,000 for benevolence work which had been placed in the budget for 1944, should be eliminated therefrom.

It was agreed that the moneys to be transferred to the Physicians' Benevolence Fund through allocation of $1.00 per active member per year should be placed to the credit of the Physicians' Benevolence Committee in its operating account. Other funds received through bequest or donation, etc., will be kept in a separate savings account, under the supervision of the nonprofit corporation, "Trustees of the California Medical Association."

5. California Industrial Accident Commission—Fee Schedule:

(*a*) Report was made by Mr. Peart for the special Committee on Fee Table. Mr. Peart referred to the meetings with the members of the California Industrial Accident Commission and outlined the proposals that had been made.

Attention was called to the fact that the Oregon State Medical Society had an experience somewhat similar to that of California, and was able to convince the Oregon State Industrial Accident Commission of the desirability of authorizing an increase in the fee schedules for medical and surgical services; and that the new schedule of the Oregon State Industrial Accident Commission became effective on June 1, 1943.

(*b*) Reference was made to a letter dated June 9, 1943, sent by Council Chairman Philip K. Gilman to the Honorable Paul Scharrenberg, Chairman of the State Industrial Accident Commission, in which some of the issues as they appear to the California Medical Association, were indicated. After discussion, the resolution which appears below, in reference to a letter dated May 21, 1943, received from the Honorable Paul Scharrenberg, Chairman of the California State Industrial Accident Commission, was adopted. The Council felt it was important that members of the California Medical Association be acquainted with the matters under consideration.

The following resolution was adopted:

WHEREAS, The Council of the California Medical Association has carefully considered the letter dated May 21, 1943, from Hon. Paul Scharrenberg, Chairman of the Industrial Accident Commission, to the Chairman of the Council and the reply of the Chairman to said letter dated June 9, 1943; and

WHEREAS, In his said letter Chairman Scharrenberg states: "If you could, as chairman of the Council of the California Medical Association, undertake some fundamental and long-range program whereby uniform rates of medical fees are demanded and adhered to by the medical profession, with the necessary machinery for disciplinary action for infraction, etc., I feel that progress could be made and our objections may be largely overcome"; now, therefore, be it

Resolved, That in sending to each member of the California Medical Association a copy of the fee schedule applied for by the California Medical Association, together with a copy of the existing fee schedule in effect since June 1, 1920, there be enclosed an agreement to be signed by the member pledging his observance and compliance with any fee schedule approved by the Commission and requesting him to sign and forward such agreement to the California Medical Association Secretary's office, and that in such communication the attention of each member be directed to the Principles of Ethics relating to industrial practice, and that the Association, through the Council, has represented to the Industrial Accident Commission that any violations of these Principles of Ethics will render the member subject to disciplinary action; and be it further

Resolved, That the Council approves everything contained in the letter of June 9, 1943, from the Chairman to Hon. Paul Scharrenberg and hereby makes that letter the action of the Council.

(*c*) After further consideration of the subject, it was voted that a resolution of appreciation be extended to the Honorable Anthony J. Caminetti concerning investigation he has instituted concerning practices relating to Industrial Compensation Insurance. Resolution in regard to the same follows:

WHEREAS, The California Medical Association has always maintained, and again through its Council meeting at San Francisco, June 19, 1943, affirms; that the primary purpose of the Workmen's Compensation Insurance and Safety Act is the restoration of the injured worker to normal health as nearly and as quickly as possible; that this primary purpose can only be accomplished by furnishing such worker adequate medical care; and that fee splitting and the rebating of fees inevitably lower the standards of such medical service. Such practices have been condemned for many years by this Association; now, therefore, be it

Resolved, That the Council of the California Medical Association commends the action of Hon. Anthony J. Caminetti, Insurance Commissioner of California, in making an investigation of compensation insurance and practices pertaining to medical service that have grown up in connection with it, and particularly the alleged exaction by some insurance carriers of rebates from physicians attending injured workmen, and the discounting of physicians' bills for services rendered by them to injured workmen; and be it further

Resolved, That this Association furnish the Insurance Commissioner any assistance within its power in such investigation.

Because the fee schedule of the California Industrial Accident Commission applies not only to members of the California Medical Association, but to all licensed physicians, it was voted that an appropriate letter should be sent to nonmember physicians, calling attention to the issues involved.

It was voted that the Special Committee on Industrial Fee Table consisting of Council Chairman Gilman, Legal Counsel Peart, and Executive Secretary Hunton, be continued.

6. Indemnity Insurance Practices:

The subject of indemnities for surgical services as given by certain commercial insurance carriers was discussed. It was emphasized that it is important that physicians should not accept checks from such commercial carriers when the so-called indemnity refunds are for sums less than the standard fees of the community.

It was agreed that a letter should be sent to the county societies, calling attention to these matters.

7. Proposed Federal Children's Bureau Plan of Obstetrical Care for Wives and Infants of Enlisted Men:

Report was made by Councilor Karl L. Schaupp, the chairman of the special committee to consider the proposed plan of obstetrical care of wives and infants of enlisted men, and the procedures to be adopted thereunder in the State of California. This new work would be possible through a grant-in-aid that would be made to the California State Board of Public Health, acting as an agent for the Federal Children's Bureau (through the federal appropriation of $1,200,000 for the United States, included in the First Deficiency Appropriation Act of 1943, and approved May 18, 1943).

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* Reference Nos. refer to the reference numbers printed in italics which appear in the June issue of CALIFORNIA AND WESTERN MEDICINE, in minutes of California Medical Association House of Delegates.

Doctor Schaupp outlined the information in regard to the same, much of which is covered in the editorial comments which appeared on pages 313 to 317 of the June, 1943, issue of California and Western Medicine.

After full discussion, upon motion duly made and seconded, a special committee consisting of Doctors Goin, Kneeshaw, and Schaupp, was appointed to draft a resolution incorporating the views of the Council. The resolution as adopted and approved by the Council follows:

Resolution on Obstetrical Care of Wives and Infants of Enlisted Men as Adopted by the California Medical Association Council on June 19-20, 1943.

1. The Council of the California Medical Association is, when the House of Delegates is not in session, the governing body of the Association.

2. The California Medical Association Council at its 311th meeting held in San Francisco on June 19-20, 1943, having considered the problem herein discussed, adopts the following:

A. The Council approves, in principle, the objectives for obstetrical care for the wives and the infants of enlisted men as provided in the Federal First Deficiency Appropriation Act of 1943, approved on March 18, 1943.

B. The Council disapproves the method of procedure proposed, wherein the physicians who perform the obstetrical services would be obliged to accept certain fixed fees.

The Council holds:

(*a*) The patient should be permitted to choose her own physician, because in the long run that procedure will make for a quality of medical service more acceptable to the parties immediately involved, namely, the patient and the physician.

(*b*) The quality of medical care in different States and their communities depends upon many factors, not the least of which are the actual costs of giving the services involved.

(*c*) Throughout the Nation, war industry is carried on a cost-plus basis. Members of the medical profession likewise earn their livings through their industry. Physicians, nevertheless, have given hundreds of thousands of dollars to the Government in gratuitous work in Selective Service and other agencies. The maintenance of high standards of medical service is a principle to which physicians are definitely committed.

The establishment of a mandatory fee table under primary control of a nonmedical bureau is a menace to the quality of present- and future-day medical service.

Physicians object to the institution of mandatory and inelastic fees that do not take into proper consideration all factors involved; therefore be it

Resolved, That it is the opinion of the California Medical Association that the California State Board of Public Health, when it receives the federal grant-in-aid for this service to wives and infants of enlisted men, should establish an allocation of money to be paid to the patient, who shall use it in making her arrangements with the physician of her choice.

8. Committee on Public Policy and Legislation:

(*a*) The Chairman of the California Medical Association Committee on Public Policy and Legislation, Dr. Dwight H. Murray of Napa, gave a summary of the legislation enacted by the Fifty-fifth California Legislature which convened in January of 1943, and adjourned on May 5, 1943.

The report on the various bills appeared in the June issue of California and Western Medicine, on pages 372-374.

Mr. Ben Read, Secretary of the California Public Health League, spoke of some of the experiences, with special relation to bills of particular interest to medical practice and public health.

(*b*) The value of a more active policy in connection with national legislation related to medical practice and public health measures was also considered. It was felt that it would redound to the best interests of the public health if the American Medical Association would devise a plan whereby constituent state medical associations would be kept in better touch with pertinent federal legislation, so that the State Medical Associations would in turn be able to communicate with their component county societies and their members, and enlist more active coöperation for measures designed to maintain high standards of medical practice.

9. California Physicians' Service:

A discussion of medical service problems with special reference to the activities of California Physicians' Service in the Federal Housing Projects coming under the jurisdiction of the Federal Housing Authority became the subject of discussion at the postluncheon meeting of Saturday afternoon.

For initial reference concerning the matters that were discussed and the issues submitted to the Council, see minutes of the House of Delegates which appear in the June, 1943, issue of California and Western Medicine (Reference No. 15 on page 351, and Reference No. 49 on page 363).

The discussion was participated in by representatives of the San Diego County Medical Society (Doctors W. H. Geistweit, Jr., Secretary; Edward A. Blondin, and Bryant R. Simpson); the Solano County Medical Society (Doctors Carl A. Snoddy, F. Burton Jones, and Howard R. Madeley); the Federal Housing Authority (Mr. Langdon W. Post, Regional Director; Mr. William Reidy, and Mrs. Marion Beers Howden); and California Physicians' Service (Doctors A. E. Larsen, Secretary; T. Henshaw Kelly and Alson R. Kilgore, members of the Board of Directors).

The presentation of issues involved was made by the representatives in the above sequences:

San Diego County.—For San Diego County, Doctor Geistweit outlined some of the conditions in San Diego Housing Projects which led to differences of opinion and misunderstanding between members of the San Diego County Medical Society and California Physicians' Service.

It was stated the housing projects had become restricted zones and that it was impossible for physicians other than the employees of California Physicians' Service to secure residence or office facilities in the housing project areas; also that about 55 per cent of the persons living in the Linda Vista Project were not covered by California Physicians' Service. He stated that it was, therefore, difficult, particularly in connection with this work, for physicians in private practice outside the area to carry on their work advantageously. Reference was made to the screening process which had been instituted in the San Diego projects whereby patients with serious illnesses would be referred to other physicians in San Diego, and the difficulties in connection therewith were pointed out.

The above and other points were brought out in the discussion by Doctors Simpson and Blondin. Doctor Blondin stated that information received by the San Diego County Medical Society through a questionnaire sent to state and county societies in other sections of the United States where housing projects exist, indicates that no such sharp limitation of who and what physicians shall practice in housing project areas is in operation in other portions of the country.

The incomes of residents in housing projects were also mentioned, one family having a monthly income of $700 and yet coming under the California Physicians' Service coverage.

The distance of the housing projects from the city, with the dim-outs in operation, made it difficult for doctors in practice in San Diego to answer emergency calls, especially at night, because there had been no opportunity to become acquainted with the street and house locations.

The manner in which the residents of housing projects had signed up for coverage was also discussed.

Queries and comments were put by members of the Council in efforts to secure more detailed information and to clarify some of the issues which had been brought out. It was emphasized that in all these matters, it was necessary to have an approach that would take into proper consideration, State, rather than purely local problem situations.

Solano County.—For the Solano County Medical Society, Dr. Carl A. Snoddy made the initial presentation, informing the Council that since the onset of the war, the population of Vallejo has trebled and was still increasing. Doctor Snoddy recalled the meeting with members of the California Medical Association Executive Committee at which a policy was approved whereby California Physicians' Service should maintain contact relations with the Solano County Medical Society in any changes of plan, or in the institution of any new housing project work.

Doctor Madeley of Vallejo took up the discussion and presented a report in which were outlined some of the problems which the Solano County Medical Society felt should be properly solved. (This report is on file in the California Medical Association office.)

Federal Housing Authority.—For the Federal Housing Authority, Mr. Langdon W. Post, Regional Director, outlined the efforts of that organization to provide adequate medical service for persons who are given residence facilities in housing project areas. Mr. Post stated that no compulsion is used concerning medical service, but that the medical service items are mentioned just as are rent for shelter, and utilities.

Some of the problems in connection with the Carquinez Heights Project were referred to. The importance of adequate medical care as part of the joint war effort was emphasized. Mention was made of the new projects that are impending, which may come into existence almost over night.

The menace of epidemics which might seriously interfere with the war effort was brought out. Mr. Post complimented California Physicians' Service on the excellent work it had carried on and said he doubted whether any plan could be brought forward that would not make for some inconvenience and hurt to certain groups. He stated that as far as the District Housing Authority is concerned, the administrators are obliged to provide adequate medical care for persons in their respective areas. Mr. Post said the problems which have arisen in California in connection with housing projects are of greater scope and more difficult of solution than had come into being in any other State in the Union. He acknowledged that at times and in some places the paper plans were not working out as efficiently as could be desired.

In answer to a query by Doctor Cline on what would happen if California Physicians' Service moved out of the San Diego project, Mr. Post replied that he would be obliged to turn to the United States Public Health Service for aid. Councilor Kneeshaw asked what assurance he had that Public Health Service would be able to give much better service, and he replied that he did not know whether it could.

Councilor McClendon called attention to the fact that there seemed to be much fret over the 50 per cent of residents who are covered by California Physicians' Service, but seemingly little attention was being given to the 50 per cent of housing area residents who did not come under such coverage.

Councilor Goin put the question as to why it should not be permissible for private practitioners to also practice in the housing project areas. Councilor McClendon called attention to the fact that the ruling laid down in California is seemingly limited to this State, namely, that only certain physicians shall be permitted to practice in particular housing project areas.

Mr. William Reidy of the Federal Housing Authority supplemented the remarks by Mr. Post, calling attention again to the rapid increase of population in some of these units. It is possible that some of the misunderstandings arose because of improper presentation at the very outset by the sales representatives, when applicants for houses in the projects applied for residence allocations.

Councilor Green called attention to the fact that representatives of California Physicians' Service had failed to maintain contacts with the county societies before engaging in modifications or new work, and that such action was not in accord with the initial agreements between the county societies and California Physicians' Service.

The question of cost of adequate medical coverage for a family came up, and statements were made that it was hoped that the charges therefor could be increased to cover actual cost of the service.

Mr. Reidy stated that the rent schedule could not be raised, but that the medical service schedule could be changed and the applicants for housing so informed.

Motion was made and unanimously carried that the representatives of the Federal Housing Authority be thanked for the presentation they had made concerning the problems confronting that agency.

California Physicians' Service.—Through its representatives, California Physicians' Service presented some of the difficulties that had been encountered in the effort to provide adequate medical coverage for residents of housing areas.

Reference was made to the early experiences of California Physicians' Service in attempting to provide "full coverage," and later, the "two visit deductible coverage." It was felt that some of the unrest existing today among physicians has resulted from the fact that the unit values for professional services, authorized four years ago, have not been brought up to the 100 per cent level.

California Physicians' Service, in its experience with the Farm Security Administration, has found that the Government is willing to act in proper coöperation, and on the basis of that governmental experience, California Physicians' Service agreed to take up the housing project work in the Linda Vista Project in San Diego County, and in the Vallejo Project in Solano County.

Doctor Kelly stated that on June 18, the Trustees of California Physicians' Service had put in an entire day in discussion of these various problems. Also, that the experiments which were being carried on in California were now being watched by interested groups throughout the United States.

Dr. Alson R. Kilgore followed Doctor Kelly, outlining other problems which had confronted the Trustees of California Physicians' Service. He called attention to impending changes in medical practice in general, as evidenced by Federal and other legislation and endeavors. He felt that it was important that the medical profession should give full coöperation to California Physicians' Service.

Council Chairman Gilman read a letter from Dr. Harold A. Fletcher, the Chairman of the California Committee on Procurement and Assignment, emphasizing the value of coördination in all this work.

Dr. A. E. Larsen, secretary of the California Physicians' Service, also spoke, saying that full coördination was a very difficult problem in these proceedings. He outlined the administrative structure of California Physicians' Service and pointed out how, in its endeavors to carry on its work in housing projects, some of the experiments necessarily had to be on the basis of trial and error. California Physicians' Service was making efforts to improve public relations and to create better understanding with both the Housing Authority and with the tenants.

He spoke also of the difficulties of working with committees whose members often failed to gather when it was necessary to discuss and endeavor to solve problems.

General discussion followed, after which the Council recessed to take up further consideration of the above and related problems on the next day, Sunday, June 20.

10. Survey of California Medical Service and Hospitalization Organizations—Report of Mr. John R. Mannix, Detroit:

The survey of California medical service and hospitalization organizations referred to under Item 10 of the Council minutes of the 306th meeting, held on February 28, 1943, (California and Western Medicine, April, 1943, page 239)—came up for consideration when a report by Mr. John R. Mannix, Director of the Michigan Hospital Service, Detroit, Michigan, was submitted. His report, "Voluntary Health Plans in California," was based on a survey made by him during the months of April and May, 1943, during which period he was in residence in California (upon invitation and contract with the California Medical Association).

Copies of the survey report having previously been sent to members of the Council, its members proceeded to consider the same.

After discussion, it was voted that the first 19½ pages, down to the subsection on "Recommendations" be received and placed on file.

Succeeding paragraphs were then considered in turn, the Council making the following changes:

Page 20.—Under item 1, the words "and the American Medical Association" were added, making that particular sentence read:

> "It should be developed in accordance with the approval standards adopted by the American Hospital Association *and the American Medical Association.*"

Page 21.—Under item 2, the words "by their duly constituted representatives" and "in active practice" were inserted, making that particular sentence read:

> "It is recommended that coördination at the trustee level be obtained by election to the medical plan board by participating hospitals in the statewide plan of a number of trustees to be later agreed upon, and further, that there be elected by participating physicians, *by their duly constituted representatives* in California Physicians' Service, an equivalent number of physicians in active practice, to serve on the hospital plan board."

Again on the same page, the words "who shall be physicians in active practice" were inserted, making that particular sentence read:

> "It is proposed that there be an executive committee made up of an equal number of representatives from California Physicians' Service, *who shall be physicians in active practice*, and the Hospital Service Plan Board; this executive committee to be responsible for the operation of both corporations."

Page 22.—On this page, the word "executives" was added, making that sentence read:

> "This executive should be an individual who would have the confidence of the medical profession and hospital *executives*, and who has an understanding and sympathetic interest in private practice of medicine and the voluntary hospital system."

At the bottom of page 22, and carrying over to page 23, deletions were made in the last sentence, commencing "This arrangement would seem to meet all the objections," etc., and ending with the words "prepayment plans," and the succeeding sentence, ending with the words "on a prepayment basis" in the first paragraph on page 23.

The portions deleted follow:

> "This arrangement would seem to meet all the objections which radiologists, pathologists and anaesthesiologists have raised, regarding the inclusion of services of these specialists in prepayment plans. These groups believe that such services should be offered by the medical plan rather than by the hospital plan. On the other hand, the public in many cases wishes to avail themselves of the services of these three specialists on a prepayment basis even though they may not in the first instance be ready to provide for other medical services on a prepayment basis."

On page 23, additional words were inserted as follows: "certain medical services," and "service," "limited," and "contract," making the last sentence of first paragraph on page 23, read as follows:

> "This would permit the offering to the public of a contract for hospital service, as well as an additional contract for certain medical services."

and again:

> "5. It is proposed that there should be a detailed actuarial study of the medical *service* plan and the *limited* surgical *contract* with the thought of offering services as comprehensive as possible at a subscriber's rate which will be attractive and which at the same time will assure the profession an adequate fee for its services."

In the discussion which followed, Council Chairman Gilman read a letter, dated June 12, from Anthony J. J. Rourke, M. D., requesting copies of the decision of the Council in relation to the report by Mr. Mannix, in order that the same might be presented at a meeting of the Association of California Hospitals Board to be held on June 26. It was so agreed.

After further discussion, on motion duly made and seconded, it was voted that the report of Mr. Mannix as submitted and as amended, be adopted as a whole.

It was agreed that copies of the Mannix Survey Report as amended should be sent to all interested groups and parties for their confidential consideration.

The liaison committee, consisting of Councilors Cline, MacDonald, and Dewey, was continued.

General discussion followed and was participated in by Doctors Cline, MacDonald, Schaupp, and Kindall, and other Councilors. Doctor Kindall spoke with particular reference to the problems which had arisen in Alameda County, pointing out some of the procedures which had caused confusion and opposition in Alameda County.

Doctor MacDonald spoke of somewhat similar conditions which had come to the front in Sacramento County.

It was agreed that it was extremely important that action should be taken at the earliest possible moment to prevent further misunderstandings by the medical service and hospitalization groups.

Other matters pertaining to personnel of the various medical service and hospitalization boards also received informal comment.

The policy which seems to exist in California whereby residence and office facilities are denied private physicians who are not officially connected with California Physicians' Service, again became the subject of discussion, and it was agreed that an effort should be made to secure the consent of the local Housing Authorities in the respective districts, so that a more liberal policy might be instituted, through which physicians in private practice would be in position to render medical care for those residents of housing project areas who are not covered by California Physicians' Service contracts.

It was also agreed that efforts should be made to bring about a better understanding between California Physicians' Service and the San Diego and Solano County Medical Societies.

On motion duly made and seconded, it was voted that the Council request California Physicians' Service and the three hospitalization groups in California (Hospital Service of California, Hospital Service of Southern California, and Intercoast Hospitalization Insurance Association), to refrain from carrying on active selling campaigns for any kind of contracts, until a merger or decision thereon as outlined in the Mannix report is brought into being. This, however, *not* to interfere with contracts previously made; and particularly not to interfere with agreements previously made with governmental authorities.

It was agreed that over the name of the medical service-hospitalization liaison committee, of which Doctor Cline is chairman, a letter should be written to the Solano and San

Diego County Medical Societies informing them of the various actions taken and to express the hope that a betterment of the issues under discussion may be brought into being, satisfactory to all concerned.

11. California Medical Association House of Delegates —Instructions Therefrom:

(A) *Committee on Scientific Work:*

(a) *Annual Session in 1944.*—The Committee on Scientific Work through its chairman, Doctor Kress, presented a supplementary report. Upon motion duly made and seconded, it was voted that the California Medical Association hold an annual meeting in 1944 along the same lines as 1943, namely, a two-day session to be held on some Saturday and Sunday, provided war exigencies do not interfere. The time and place of such annual meeting, if held, to be left for future consideration by the Council.

(*b*) It was agreed that it was desirable to bring California physicians who are acting as health officers in closer affiliation with their fellow practitioners in private practice. The Committee on Scientific Work was given permission to provide a *separate public health program* in case an annual session is held in 1944. (Reference Nos. 26-44, June California and Western Medicine, on page 356.)

(*c*) Approval was also given to the suggestion of Reference Committee No. 1 (Reference No. 27) to feature a "round-table discussion on practical points and of methods and procedures found useful by men in general practice."

(B) *Public Relations Publicity Committee:*

In accordance with Reference No. 32 (page 357) in the minutes of the House of Delegates, the Chairman of the Council was authorized to appoint a subcommittee of its own members to be called the Public Relations Publicity Committee, said committee to coöperate and advise with the Secretary of the Association and the Executive Secretary for the purpose of carrying on a consistent campaign in behalf of the best interests of the medical profession and general public health."

The committee appointed for this purpose consists of: R. Stanley Kneeshaw, San Jose, Chairman; E. Vincent Askey, Los Angeles, and Edwin L. Bruck, San Francisco.

(C) *Annual Conference of County Society Secretaries and State Association Officers and Committeemen:*

In reference to House of Delegates Item (Reference No. 33, on page 358), it was agreed that as per the recommendation made by the House of Delegates concerning meetings of County Society Secretaries and Officers and Committeemen of the California Medical Association, such meetings should be "subject to the exigencies of war." Decision concerning such meeting or meetings will be made by the Council at a subsequent meeting.

(D) *Councilor Districts:*

The House of Delegates Item (Reference No. 36 on page 359) concerning areas involved in Councilor Districts was considered and it was agreed that in as much as the House of Delegates had made no change, the arrangement as at present existing should be maintained. (Constitution, Article IV, Section 9.)

(E) *Physicians' Benevolence Committee:*

(*a*) Concerning the recommendations included in the resolution submitted to the House of Delegates (Reference No. 6 on page 349), it was agreed that the Physicians' Benevolence Committee must decide amounts to be paid to individual physicians who may be deemed worthy of aid. It was felt, however, that the needs of members or of former members of the California Medical Association should receive prior consideration to the needs of physicians who have never been members of the California Medical Association. Further, in cases where such conditions arise, a courteous letter of inquiry should be sent by the Physicians' Benevolence Committee to the State Association and to the County Medical Society of which nonmember physicians in need might formerly have been members, calling attention to the nonmember physicians' circumstances.

(*b*) Regarding the Physicians' Benevolence Fund, as provided through the California Medical Association Constitutional amendment (Article XI, Section 1), adopted by the House of Delegates on May 3, 1943 (Reference No. 39 on page 359), it was agreed concerning the $1.00 allocation received each year from active members whose dues had been forwarded by component county societies, that the current or operating expense of the Physicians' Benevolence Committee should be limited to the money so received which would be held in a separate account of the California Medical Association; it being provided that all other moneys received through bequest, donation, or otherwise, should be maintained in a separate savings account under the jurisdiction of the "Trustees of the California Medical Association."

(F) *Postwar Plans of Medical Service and Social Security:*

In accordance with the item in the minutes of the House of Delegates (Reference No. 42, on page 360), the Council authorized the Council Chairman to appoint a special committee to study postwar problems and bring in a report thereon to the Council for further consideration.

The committee appointed for this purpose consists of: Dewey R. Powell, Stockton, Chairman; Donald Cass, Los Angeles; and John W. Green, Vallejo.

(G) *Revision of the American Medical Association Principles of Medical Ethics in Relation to Postwar Problems:*

The House of Delegates action (Reference No. 45, on page 362), calling for consideration by the Council of the desirability of making certain changes in the Code of Ethics of the American Medical Association was discussed. It was agreed that the Council Chairman should appoint a committee to make a study and bring in a report to the Council, so that it may be determined whether recommendations should be made thereon to the California Medical Association delegates who will attend the meeting of the House of Delegates of the American Medical Association in 1944.

The committee appointed for this purpose consists of: Lowell S. Goin, Los Angeles, Chairman; John W. Cline, San Francisco; and William R. Molony, Sr., Los Angeles.

(H) *Appointment of Special Committees of Senior Physicians, etc.:*

The needs of medical personnel for the Army and Navy, with special relation to the quota still to be filled by the State of California, was discussed. Reference was made to the letter of June 7, received from the Directing Board of the Federal Procurement and Assignment Service in which it was stated that it would be necessary as of May 15, 1943, for California to supply 535 additional physicians for the armed forces in order to fill its quota in relation to other States in the Union.

The Council voted to recommend to component county societies which have not filled their respective quotas, the advisability of appointing committees of senior physicians to coöperate with their local Committees on War Participation, in the manner outlined in the resolution considered by the California Medical Association House of Delegates (Reference Nos. 11 and 46, on pages 350 and 362).

(I) *Concerning Postgraduate Courses for Military Members:*

The subject was considered by the House of Delegates (Reference No. 4 and No. 40, on pages 349 and 359). As suggested by the House of Delegates, it was agreed that the Council Chairman should appoint a committee as outlined in Reference No. 4 to make a study and report thereon to the Council.

The committee appointed for this purpose consists of: Calvert L. Emmons, Ontario, Chairman; Harry E. Henderson, Santa Barbara; Lloyd E. Kindall, Oakland; and ex officio (from the California Medical Association Postgraduate Committee, its chairman and secretary) R. E. Clough, San Bernardino, and George H. Kress, San Francisco.

12. Miscellaneous and New Business:

(a) *Conference with State Bar Association—Delinquency Problems:*

A letter, dated June 8, from Thomas Parran, Surgeon General of the United States Public Health Service, requested the coöperation of the California Medical Association with the California State Bar Association concerning prostitution and delinquency problems. It was agreed that a letter should be sent to the President of the California Bar Association, Frank B. Belcher, Esq., Security Building, Los Angeles, California, offering such coöperation.

(b) *Loss of Equipment at Del Monte:*

Attention was called to the fact that the Association had in storage at the Hotel Del Monte equipment to the value of $800 to $1,000, and that after the United States Navy took possession of the hotel, the property seemingly disappeared. The legal counsel was instructed to send proper communications to the Hotel Del Monte authorities and to the United States Navy, to make the loss a matter of record and to inquire on what could be done in the premises.

(c) *Approval of Resolutions of Pacific States Medical Executives' Conference:*

Report was made by Captain Gilman, who presided at the meeting of the Pacific States Medical Executives' Conference, concerning actions taken by that organization at its meeting held in Portland on May 29 and 30.

It was agreed that the resolutions adopted by the organization receive the approval of the California Medical Association. (For resolutions, see June issue of CALIFORNIA AND WESTERN MEDICINE, pages 375-376.)

(d) *Interim Committee Appointments:*

Interim appointments made by the Council Chairman to various committees were approved.

(e) *Osteopathic Practice Act:*

Councilor Henry S. Rogers, who was one of the California Medical Association delegates at the meeting of the House of Delegates of the American Medical Association, held in Chicago on June 7-10, 1943, reported that he had been present at a meeting of the American Medical Association Council on Medical Education, and that he had taken occasion to inform those committeemen concerning the correspondence that had gone forward a year or so ago to the American Medical Association Council on Medical Education and the Association of American Medical Colleges, concerning the Osteopathic Practice Act in California, and related matters. Doctor Rogers stated that the members of the American Medical Association Council on Medical Education were in a receptive mood to learn further of the effort made last year by the California Medical Association concerning steps proposed by some of the osteopathic group, whereby the Osteopathic Practice Act initiative would be submitted to the electorate, thus permitting such members of the osteopathic group to consider completion of their healing arts education, in line with the curriculum standards set by the two national medical organizations.

It was agreed that a letter should be written to the deans of the four medical schools in California suggesting that the matter be reopened through correspondence with the Council on Medical Education of the American Medical Association, and the Association of American Medical Colleges.

(f) *Report on the Meeting of the American Medical Association House of Delegates:*

Report was made by Councilors William R. Molony and Lowell S. Goin on the meeting of the American Medical Association House of Delegates held in Chicago June 7-10, 1943.

Report of this meeting appears in the *Journal of the American Medical Association,* June 19, 1943, page 517, and June 26, 1943, page 612.

(g) *Salary of Executive Secretary:*

In executive session of the Council, it was voted that the salary of Executive Secretary Hunton be increased by $700 per year, making his salary $7,600 per year.

(h) *Agricultural Workers Health and Medical Association:*

Report was made by Doctor Schaupp concerning the letters sent to congressmen urging appropriation for the work of the Agricultural Workers Health and Medical Association. It was voted that the Council go on record as opposing contracts by county hospitals located in California, with federal or other agencies, through which care would be provided for nonindigent persons, except in cases of compelling urgency.

(i) *Conference Committee—Hospitals, Nurse and Medical Societies:*

It was agreed that a special committee be appointed to confer with the Association of California Hospitals, the State Nurses' Association and other interested groups, concerning ways and means through which a betterment of controversial issues might be brought about.

13. Date of Next Meeting:

It was agreed that the next meeting should be held in San Francisco on Sunday, August 22, but if a two-day meeting should become necessary, it would be held on Saturday and Sunday, August 21-22.

14. Adjournment:

Upon motion duly made and seconded, it was voted to adjourn.

PHILIP K. GILMAN, *Chairman.*
GEORGE H. KRESS, *Secretary.*

OFFICIAL NOTICE

Proposed Amendment to Article IV, Section 1 (c) of the Constitution of the California Medical Association. (See June, 1943, "California and Western Medicine," Reference No. 5, on page 349.)

Section 1 (c) of Article IV of the Constitution of the California Medical Assocation is hereby amended by adding, immediately after the first paragraph contained in said Section 1 (c) a full new paragraph:

If an application for retired membership is submitted by a component medical society within the calendar year immediately succeeding the last calendar year in which the recommended applicant was an active member in good standing, the Council shall have authority to act on such application as though it had been submitted in the preceding calendar year during which active membership existed.

So that the said Section 1 (c) of Article IV will, therefore, read:

(c) Retired Members

Qualifications.—Retired members of the California Medical Association shall be elected by the Council on the recommendation of any component county society from those active members thereof who cease the practice of medicine for reasons satisfactory to such component county society and the Council, and who shall have been active members of the Association for ten years or more prior thereto.

If an application for retired membership is submitted by a component medical society within the calendar year immediately succeeding the last calendar year in which the recommended applicant was an active member in good standing, the Council shall have authority to act on such application as though it had been submitted in the preceding calendar year during which active membership existed.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

On Procurement of Adequate Medical Personnel for the Armed Forces*

(EDITOR'S NOTE—*Copy of a Directive (Form 258 of June 5, 1943) from Federal War Manpower Commission. Directive implies an important change of procedure regarding voluntary enlistments, to apply to all physicians under age of 45. The Directing Board of the Procurement and Assignment Service is under the chairmanship of Dr. Frank H. Lahey of Boston.*)

* * *

(COPY)

June 7, 1943.

TO: *State Chairman for Physicians* (States with quotas).

FROM: *Directing Board, Procurement and Assignment Service.*

SUBJECT: *Change in Recruitment Procedures.*

Although State Chairmen have declared considerable numbers of physicians available for military duty, many of these men have not seen fit to apply for commissions. Recruitment methods which have been used in the past have not produced the number of physicians who can be spared from the civilian population for service as medical officers nor have they produced the number urgently needed by the armed forces.

In view of these facts, a new recruitment procedure has been agreed upon by the Procurement and Assignment Service and the Army and Navy which will supplement the methods now being used by this Service. Under this new procedure, representatives of the Officer Procurement Service and the Office of Naval Officer Procurement in your State will interview men, whom you have declared available, in order to persuade them to apply for commissions.

* * *

You are, therefore, requested to list by name and address all physicians under 45 years of age in the following three categories who are available or who can be declared available:

* * *

(1) *Physicians who have indicated choice of military service by sending you Form No. 174. "Preference for Service," but who have failed to apply for commission.*

(Copies of these lists are to be turned over *immediately* to
(Name)
________________, Officer Procurement Service________
(Address) (Name)
________________ or to ________________,
(Address)
District Office of Naval Officer Procurement, ________
________________. A third copy is to be sent to the Central Office of Procurement and Assignment Service.)

* * *

(2) *Physicians who have been sent letters of invitation but who have never indicated choice of service.*

(As soon as this list has been prepared, you are requested
(Name)
to confer with ________________, Officer Procurement Service and ________________, District Office of Naval Officer Procurement for the purpose of distributing names to both the Army and Navy on a fair basis. The ratio of relative strength of the Army and Navy which is 8:3 will probably be the basis for distributing names.)

(3) *Physicians who will be declared available by you for the remainder of the year and to whom letters of invitation have not yet been sent.*

(This entire list should be sent immediately to the Central Office so that letters of invitation may be mailed out. After you have sent this list to the Central Office, you should call in the Army and Navy representatives in order to arrange for a distribution of names according to the 8:3 ratio.)

* * *

Clearances must be given to the Army and Navy for men in all three groups described above. Presumably you have already supplied availability clearances on group (1) to the Army and Navy, but it may be necessary to fill out new availability clearances. You have already forwarded professional clearance forms on group (1).

For group (2) you should have in your files availability and professional clearance forms received from us at the time the invitations were issued. Nevertheless, a supply of clearance forms is being sent you for this purpose.

For group (3) the Central Office will prepare clearance forms, forwarding them to you for each name you submit at the time invitations are issued.

* * *

At regular intervals, the Army and the Navy will return to you the names of men who have not accepted commissions. You will submit these names to the State Director of Selective Service, asking that consideration be given to draft reclassification. A copy of your letter to the State Director of Selective Service, together with the names of men whose reclassification you have requested. should be sent to the Central Office so that the information may be transmitted to National Headquarters, Selective Service System.

* * *

In addition to the three categories of physicians described above, you will soon receive lists of interns and residents who, according to their hospital superintendents, will be available and who have not yet been commissioned. You should check these lists carefully in order to make a final determination of the status of each individual. After this has been done, you should call another conference with the procurement representatives of the Army and the Navy in order to distribute the names fairly on the basis of the 8:3 strength ratio. You should also prepare clearance forms on each individual whose name is turned over to the Army or the Navy.

Within a short time, you will receive another memorandum regarding the classification of all remaining physicians in your State according to the class numbers of the Procurement and Assignment Service Classification Card. If you have not already done so, your classification cards should be brought up to date as soon as possible.

From: Directing Board, Procurement and Assignment Service.

* * *

States With Quotas [Unfilled]
Reference Paragraph 3, Form 258

Number of physicians to be made available according to Procurement and Assignment estimate as of May 15, 1943:

CALIFORNIA	535	Nebraska	61
Colorado	11	Nevada	5
Connecticut	206	New Hampshire	27
District of Columbia	55	New Jersey	144
Illinois	420	New York	1500
Iowa	44	Ohio	300
Maryland	76	Oregon	0
Massachusetts	300	Pennsylvania	640
Minnesota	205	Rhode Island	60
Missouri	353	Vermont	2

Wisconsin, 30

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* For editorial comment see page 2.

On Change in Recruitment Procedures. Re: Civilian Practice.

Office for Emergency Management
War Manpower Commission

Washington 25, D. C., June 5, 1943.

Procurement and Assignment Service for
Physicians, Dentists and Veterinarians

To: *State Chairmen for Physicians* (States without quotas).

From: *Directing Board, Procurement and Assignment Service.*

Subject: *Change in Recruitment Procedures.*

Although your State has not been assigned a quota for this year, you have informed the Central Office that .... physicians are not essential in the localities where they are now practicing.

In your State, there are localities where physicians are needed. Will you communicate with the physicians whom you have declared to be available and request them to relocate in areas of medical need. If, after two weeks, these physicians do not comply with your request, you should send a list of their names and addresses to the Central Office. The Central Office will prepare letters asking them to apply for commissions.

As soon as you receive clearance forms on these physicians, lists of their names should be given to the Officer Procurement Service and the District Office of Naval Officer Procurement. You should call in the Army representative of the Officer Procurement Service, ..., and the Navy representative of the District Office of Naval Officer Procurement, ..., as soon as your lists are ready so that they may both begin contacting these available physicians immediately. The lists will include those who have indicated preference, as well as those who have not returned their cards. In case of preference, they can be referred to the proper branch, and those who have not returned their cards can be turned over to both branches, distributing them on the ratio of 8:3 (Army to Navy). Copies of these lists should also be sent to the Central Office. In addition, you should send to the Central Office the names of physicians who have relocated as a result of your efforts. You should begin this work at once, making sure that all efforts to relocate available physicians have failed before their names are turned over to the representatives of the armed forces.

Directing Board,
Procurement and Assignment Service.

(copy)

States Without Quotas [Quotas Filled]

Alabama
Arizona
Arkansas
Delaware
Florida
Georgia
Idaho
Indiana
Kansas
Kentucky
Louisiana
Maine
Michigan
Mississippi
Montana
New Mexico
North Carolina
North Dakota
Oklahoma
South Carolina
South Dakota
Tennessee
Texas
Utah
Virginia
Washington
West Virginia
Wyoming

"We Americans can not successfully maintain even our domestic freedom here, unless we help to restore freedom in every land where it has been threatened or wiped out. That is not an academic question: it is a question of life and death for all that humanity holds dear. And as such, it is an immediate summons to action."—Lewis Mumford.

FEDERAL CHILDREN'S BUREAU PLAN*

RE: MATERNITY AND PEDIATRIC CARE FOR WIVES AND INFANTS OF ENLISTED MEN

ITEM I

Letter to Los Angeles Subcommittee Concerning California Fee Schedules:

(copy)

California Medical Association

San Francisco, May 24, 1943.

Attention:
Donald G. Tollefson, M. D., Chairman
Los Angeles Subcommittee
Los Angeles, California

Dear Doctor Tollefson:

On Saturday last, with Chairman of the California Medical Association Committee, Dr. Karl L. Schaupp, I attended a meeting in the office of the California State Board of Public Health. Dr. Jessica Bierman of the State Board of Health, in Los Angeles will take up the discussion with your subcommittee tomorrow (Tuesday, May 25).

Dr. Edward Daily, of the Federal Children's Bureau, when he was with the Northern Committee made the statement that they had worked out the prospective scale of prices on the basis of some 300 fee tables supplied by the American Medical Association, and in no instance did a single fee table list a charge of more than \$35 for a simple confinement.

I told them I could not understand that, because I knew the fee tables in Los Angeles were higher. . . .

In the meantime, for your information, I have found fee tables, with years adopted, in our own files, for the following societies:

Sonoma County: Ordinary labor, \$50 to \$75; difficult labor, requiring instrumental interference, \$75 to \$150. Year 1928.

San Luis Obispo County: Confinement cases, \$50 up. Year 1932.

San Mateo County: Uncomplicated labor, \$50 and up; abnormal presentation, \$25 extra; instrumental delivery, \$25 extra. Year 1925.

San Joaquin County: Ordinary obstetric cases, \$50; instrumental, \$75 to \$100. Year 1919.

Orange County: Uncomplicated labor, \$35 to \$75; abnormal presentation, \$25 extra; version, \$25 to \$50 extra; instrumental delivery, \$10 to \$25 extra; Caesarean section, \$150 to \$500. Year 1933.

The above may be of use to you in case the matter comes up for discussion.

Cordially yours,
George H. Kress, M. D.,
Secretary.

* * *

ITEM II

Letter to American Medical Association Secretary West Regarding Obstetric Fee Schedules:

(copy)

California Medical Association

San Francisco, June 1, 1943.

Olin West, M. D., Secretary
American Medical Association
Chicago, Illinois

Dear Doctor West:

On Saturday, May 22, 1943, a meeting was held in the office of the California State Board of Health in San Francisco, at which Doctor Daily of the Children's Bureau was present. The subject of discussion was the proposed work outlined by the Federal Children's Bureau having to do with maternity and infant care for wives and infants of men in the Armed Forces.

You have, no doubt, seen the six-page folder put out by the Children's Bureau, in which the proposed plan is outlined.

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* For editorial comment see page 1.

As we understand it, the federal representatives are contacting the state health boards to whom the payments of grants-in-aid will be made, in order to secure coöperation between the state health boards and the state medical societies.

At our San Francisco meeting we were very much surprised to have Doctor Daily inform us that, prior to working out presumable fee schedules, they had secured from the American Medical Association the fee tables our National Organization had in its files, and that in some 300 fee tables that had been passed over, not one had an allocation for confinement work in excess of $35. I told Doctor Daily that I knew that in California heavier fees than that had been in operation for years.

I enclose a copy of a letter dated May 24, which was written to Doctor Tollefson, of our Los Angeles Committee, and which gives information along this line. . . .

May I ask you to check and inform us concerning the supposed 300 fee tables that were given to the Children's Bureau, with particular reference to the item mentioned above?

In a plan that will have the wide ramifications of the proposed maternity and infant care for wives and children of the men in the Armed Forces, it is important that the Federal Children's Bureau be supplied with the latest, and not antique information.

With all good wishes,

Cordially yours,
George H. Kress, M. D.,
Secretary.

* * *

ITEM III

Letter from American Medical Association Secretary West Regarding Their Files on Obstetric Fee Schedules:

(copy)

American Medical Association
535 North Dearborn Street,
Chicago, June 3, 1943.

Dr. George H. Kress
Secretary, California Medical Association
450 Sutter, San Francisco, California

Dear Doctor Kress:

Your letter of June 1 was received this morning.

Immediately after reading your letter, I conferred with Doctor Leland, who knew of no fee schedule that had been supplied to any one connected with the Children's Bureau. Some time ago the Bureau of Medical Economics collected available information concerning fee schedules and compiled this information, the compilation including some 600 items. This material has never been published and Doctor Leland informs me that it has been unavailable for use by others.

In so far as we have been able to discover, the only material that has been sent by any one conected with the Bureau of Medical Economics pertaining to medical fees for obstetric services is a copy of an article that appeared in the Organization Section of The Journal of the American Medical Association for September 30, 1939. I am enclosing a copy of this article.

I have before me a copy of a letter under date of *October 9, 1940,* addressed by Mr. Simons, of the Bureau of Medical Economics, with which the material above referred to was transmitted to Doctor Daily. This letter reads as follows:

"Dear Doctor Daily:

"The only study of the average charge by physicians in obstetric cases that has been prepared by the Bureau of Medical Economics is contained in an article by Dr. Leland, of which a copy is enclosed herewith.

"It should be understood that all fee schedules issued by county medical societies are considered only as guides to customary fees in the locality. In the income limits which you suggest (between $1200 to $3600 per year) such fees would be especially subject to individual adjustments by the physicians to meet the economic ability of the patient."

In 1937, our Bureau of Medical Economics received a letter from Dr. R. C. Hood, Director of the *Crippled Children's Division* of the Children's Bureau, asking for information pertaining to the cost of medical care in connection with services for crippled children. Mr. J. D. Laux, who was at that time employed by the Bureau of Medical Economics, compiled some information in compliance with that request. It was, however, definitely stated in Doctor Hood's letter that the information he asked for was intended for study by the orthopedic surgeon of the Children's Bureau concerned with the Bureau's program for aid to crippled children and that no tabulation would be sent to any state agencies. In the letter addressed to Doctor Hood by Mr. Laux, great care was taken to point out to Doctor Hood that any information pertaining to fee schedules should be used most judiciously and that fee schedules were intended to serve solely as guides and not as "clubs." As a matter of fact, the letter written by Mr. Laux was from end to end a warning about the injudicious use of fee schedules and evidently Doctor Hood was impressed, since in acknowledging receipt of Mr. Laux's letter, he assured him that the material that had been forwarded was intended only for the use of the orthopedic surgeon of the Children's Bureau.

With my sincere good wishes, I am

Very truly yours,
Olin West, M. D.

* * *

ITEM IV

Letter from Public Health Director Halverson Concerning Proposed Obstetric Plan:

(copy)

State of California
Department of Public Health

San Francisco (2), California, June 23, 1943.

Philip K. Gilman, M. D.
Council Chairman
California Medical Association
450 Sutter Street, San Francisco, California.

Dear Doctor Gilman:

We have today submitted to the Regional Office of the Children's Bureau our plan for emergency maternity and infant care for soldiers' dependents and should hear within the next week or so as to approval by the Children's Bureau.

The plan calls for the payment of $50 for obstetrical care when given by a private physician and consultation fees from $15 to $50 in addition, depending on the services rendered.

Payment for infant care is on a case-week basis at the rate of $12 for the first week and $8 for each of two succeeding weeks on any authorization.

This department, in its publicity, will make it clear that in the vast majority of cases, i.e., in the large cities, the fee is not in line with the service and that the doctor is making a definite contribution. As soon as, and when the plan is approved, copies will be made and will be sent to you.

In looking over the bill (H. R. 2041) which Congress passed and which constitutes the legal basis for this program, I note that the Children's Bureau is authorized to make "payments to states for medical, nursing and hospital maternity and infant care for the wives and infants of enlisted men in the armed forces of the United States of the fourth, fifth, sixth, and seventh grades." It is my opinion that this specific wording makes it necessary for the Children's Bureau to develop the program along the lines recommended in its Information Circular No. 13, a copy of which I sent you.

It would appear to me that the payment of a maternity benefit directly to the recipient of the service would not be possible under the present law. I inquired of the Children's Bureau whether or not any change in policy is contemplated as a result of the action taken by the House of Delegates of the American Medical Association. The answer was that no change is contemplated.

While the plan as submitted is not as either the California State Department of Public Health or the California Medical Association would like it, it seems to be necessary because of the great demand that it be initiated.

In line with our conversation this morning, I certainly trust that it will be possible for you to assist in conveying the information to the medical profession and in securing their understanding of the problem before us. You may rest assured that this Department will do everything possible to administer the program in a way that will be to the best interest of all concerned.

668 Phelan Building.

Very sincerely yours,
(Signed) Wilton L. Halverson, M. D.,
Director of Public Health.

* * *

ITEM V

Letter From Council Chairman Gilman Requesting Information From State Board:

(COPY)

California Medical Association

June 25, 1943.

Subject: Plan of Procedure by California State Board of Public Health, regarding Federal Grants-in-Aid from Federal Children's Bureau to Provide Obstetrical Care to Wives and Infants of Enlisted Men.

Wilton L. Halverson, M. D., Director
California State Board of Public Health
668 Phelan Building, 760 Market Street
San Francisco 2, California.

Dear Doctor Halverson:

Receipt of your letter of June 23, 1943, concerning the above is acknowledged.

May we suggest that publicity in regard to contemplated procedures, as outlined in your letter, be delayed by the California State Board of Public Health for at least two weeks, during which time it will be possible for the constituted authorities of the California Medical Association to consult on best ways and means of procedure, in so far as doctors of medicine are concerned.

At the meeting of the California Medical Association Council, held on June 20, the resolution enclosed herewith was adopted. (See Item VI.)

You will note that the Council holds to the view that whatever money allocation is made in this obstetrical work should be paid in each instance to the patient (the patient to choose her own physician and make her own financial arrangements with him).

Kindly inform us if you have secured a written opinion on the subject from the Legal Counsel of the California State Board of Public Health, and if so, will it be possible for you to send us a copy thereof?

Also, have you any statement in writing from the Federal Children's Bureau informing the California State Board of Public Health that it would be illegal for the California State Board of Public Health to use any of this particular grant-in-aid money if it transmitted such money as may be the designated amount for an individual patient, to such patient direct, rather than to her physician?

If so, can you send us a copy of such opinion?

At the meeting of the House of Delegates of the American Medical Association held in Chicago on June 7-10, 1943, this subject was considered and the action taken thereon will probably appear in The Journal of the American Medical Association in its issue of June 26. (Appeared on page 621 of that issue.)

The June issue of "California and Western Medicine" carries a four-page discussion of the subject on pages 313-317.

I mention these items because you may wish to refer to them.

Be assured that the members of the California Medical Association are in full accord with the objective, namely, the giving of obstetrical care of wives and infants of enlisted men; but, at the same time, the California Medical Association hopes no steps will be taken that will make for a lowered quality of professional service in the work involved, or that will lead to the establishment of procedures that can do much injury to the best interests of scientific medicine and medical practice.

Cordially yours,
Philip K. Gilman, M. D.,
Chairman of the
California Medical Association Council.

* * *

ITEM VI

Resolution of California Medical Association Council, Adopted at Its Meeting in San Francisco, on June 20, 1943:

Appendix B

Resolution on Obstetrical Care of Wives and Infants of Enlisted Men as Adopted by the California Medical Association Council on June 19-20, 1943.

1. The Council of the California Medical Association is, when the House of Delegates is not in session, the governing body of the Association.

2. The California Medical Association at its 311th meeting held in San Francisco on June 19-20, 1943, having considered the problem herein discussed, adopts the following:

A. The Council approves, in principle, the objectives for obstetrical care for the wives and the infants of enlisted men as provided in the Federal First Deficiency Appropriation Act of 1943, approved on March 18, 1943.

B. The Council disapproves the method of procedure proposed, wherein the physicians who perform the obstetrical services would be obliged to accept certain fixed fees.

The Council holds:

(a) The patient should be permitted to choose her own physician, because in the long run that procedure will make for a quality of medical service more acceptable to the parties immediately involved, namely, the patient and the physician.

(b) The quality of medical care in different States and their communities depends upon many factors, not the least of which are the actual costs of giving the services involved.

(c) Throughout the Nation, war industry is carried on a cost-plus basis. Members of the medical profession likewise earn their livings through their industry. Physicians, nevertheless, have given hundreds of thousands of dollars to the Government in gratuitous work in Selective Service and other agencies. The maintenance of high standards of medical service is a principle to which physicians are definitely committed.

The establishment of a mandatory fee table under primary control of a non-medical bureau is a menace to the quality of present- and future-day medical service.

Physicians object to the institution of mandatory and inelastic fees that do not take into proper consideration all factors involved.

Therefore, be it

Resolved, That it is the opinion of the California Medical Association that the California State Board of Public Health, when it receives the federal grant-in-aid for this service to wives and infants of enlisted men, should establish an allocation of money to be paid to the patient, who shall use it in making her arrangements with the physician of her choice.

* * *

ITEM VII

Resolution of American Medical Association House of Delegates, Adopted in Chicago on June 8, 1943:

(COPY)

Appendix A

SUBJECT: *Federal Children's Bureau Plan for Maternity Care, etc.*

The following is an excerpt from Minutes of House of Delegates of American Medical Association, Chicago, June 7-10, 1943. (See Item 1 of Report of Reference Committee on Legislation and Public Relations in *The Journal of the American Medical Association,* June 26, 1943, on page 621.)

* * *

The American Medical Association House of Delegates in Chicago, on June 8, 1943, approved the following resolution:

1. *Resolutions Expressing Approval of Federal Assistance to Wives and Children of Service Men as Outlined in Plan Under Consideration by Federal Children's Bureau, introduced by Dr. John H. Fitzgibbon, Oregon:*

"Your reference committee recommends:

(a) That the action of the federal government in making funds available for maternity and infant care for the wives and infants of enlisted men be approved, and

(b) That the adoption be urged of a plan under which the federal government will provide for the wives of enlisted men a stated allotment for medical, hospital, maternity and infant care, similar to the allotments already provided for the maintenance of dependents, leaving the actual arrangements with respect to fees to be fixed by mutual agreement with the wife and the physician of her choice."

* * *

ITEM VIII

Resolution of Pacific States Medical Executives Conference, Adopted at Its Meeting in Portland, Oregon, on May 30, 1943:

(COPY)

PACIFIC STATES MEDICAL EXECUTIVES' CONFERENCE

Resolutions adopted on May 29-30, 1943, at the Fifth Annual Session in Portland; Philip K. Gilman, California, presiding.

* * *

The Reference Committee (George E. Henton, Oregon, Chairman, Homer D. Dudley, Washington, and George H. Kress, California) recommends the adoption of the following resolutions:

RESOLUTION NO. 1

Resolved, That approval be expressed of federal assistance to the wives and children of service men as outlined in the plan under consideration by the Federal Children's Bureau; provided, however, that the constituent state medical associations which are members of the Pacific States Medical Executives' Conference, be requestd to consider carefully the merits of the procedure proposed by the Oregon State Medical Society, wherein any allocations for professional services agreed upon as compensation for obstetric work involved shall be given to the wives of enlisted men, such patients then to secure the services of physicians as they themselves deem proper, the fee for professional services to be decided by mutual agreement between the patients and the attending physicians; and

Resolved, That the Conference Secretary send outlines of the Oregon plan to the constituent state associations; and further

Resolved, The suggestion be made that a special committee composed of representatives of the Pacific States medical associations be brought into being, if possible, to further consider the above Oregon plan.

* * *

ITEM IX

Letter from Doctor Daily of Federal Children's Bureau to State Health Director Halverson:

(COPY)

CHILDREN'S BUREAU
U. S. DEPARTMENT OF LABOR
Washington, D. C., June 30, 1943.

Wilton L. Halverson, M. D.
Director of Public Health
State Department of Public Health
760 Market Street
San Francisco 2, California

Dear Doctor Halverson:

In reference to Doctor Bierman's telephone conversation of June 29 with Doctor Eliot, Congress, in appropriating funds for emergency maternity and infant care for wives and infants of enlisted men, specified that the funds were to provide medical, nursing, and hospital care. The payment of direct grants to the wives of enlisted men would give no assurance that the funds would be used to provide medical, nursing, or hospital care as specified by Congress. The appropriations for emergency maternity and infant care can be expended only by the State health agencies actually to purchase medical, nursing, and hospital care for wives and infants of enlisted men in accordance with a State plan approved by the Children's Bureau.

Sincerely yours,
EDWIN F. DAILY, M. D.,
Director, Division of Health Services.

* * *

ITEM X

Letter of Council Chairman Gilman to State Health Director Halverson Concerning Point of View Held by California Medical Association:

(COPY)

CALIFORNIA MEDICAL ASSOCIATION
July 1, 1943.

Wilton L. Halverson, M. D., Director
California State Board of Public Health
668 Phelan Building
San Francisco 2, California

Dear Doctor Halverson:

Your letter of June 29, in which you call our attention to the position of the California State Board of Public Health in the matter of the Maternity and Infant Care program of the Federal Children's Bureau, has been received and given careful consideration.

For your information, I am enclosing copy of a letter dated July 1, 1943, which has been sent to the component County Medical Societies of the California Medical Association.

The position which the Council of the California Medical Association has taken in regard to the Maternity and Infant Care program is explained therein. You will note that the California Medical Association is in full accord with the objectives of the program, namely, the giving of adequate medical care to the wives and infants of enlisted men. However, the Council of the California Medical Association, on behalf of that organization, desires that the quality of this maternity and infant care shall be maintained up to the best standards of scientific medicine. The California Medical Association does not wish to become a party to procedures in administration that are not conducive to the maintenance of the highest quality of medical service.

If you will refer to the final paragraphs on page 2 of the letter of July 1, you will note that members of the California Medical Association are privileged to proceed as in their individual judgment may be deemed most desirable, in so far as payments for professional services rendered are concerned. However, the California Medical Association does not desire to have inflicted upon its members a mandatory or other fee table that is not in harmony with established costs of service in California.

The point of view of the Council of the California Medical Association is outlined in the enclosure that has gone forward with the letter of July 1, under the caption of "Appendix B," and which is also in line with the resolution passed by the House of Delegates of the American Medical Association, as given in the enclosure marked "Appendix A."

Be assured that, as in the past and even more during present days, the California Medical Association and its members will continue to do everything possible to promote success in every and all efforts designed to develop the best interests of our Country and its citizens in both military and civilian life.

Cordially yours,
Philip K. Gilman, M. D.,
Chairman of the Council of the
California Medical Association.

* * *

ITEM XI

Letter to Members of Component County Medical Societies Concerning Procedure Available for California Medical Association Members in Relation to Obstetric Work:

(copy)

California Medical Association

July 1, 1943.

Subject: Plan of Federal Children's Bureau to Provide Obstetric and Pediatric Care for Wives and Infants of Enlisted Men.

The Members of the ———
County Medical Society, addressed

Dear Doctors:

I—Reference Items to the Children's Bureau Plan.

The important subject of maternity and infant care of wives and children of enlisted men is discussed in the June issue of California and Western Medicine (now in the mails), on pages 314-317.

The "Journal of the American Medical Association," in its issue of June 26, on page 621, prints the action of the American Medical Association House of Delegates as taken on June 8, 1943. A copy of the resolution is enclosed herewith, as "Appendix A" of this letter.

At the meeting of the Council of the California Medical Association, held on June 20, the enclosed resolution, numbered "Appendix B," was unanimously approved. (With the objectives, the California Medical Association is in accord; with the proposed procedures to attain the objectives, we are not.)

Because the issues involved are of great importance to present and future medical practice, the above items are submitted for the careful consideration of the members of your County Society.

II—Position of the California State Board of Health.

Through conferences and letters (copies of which have been sent to California Medical Association Councilors), the State Board of Public Health has explained to California Medical Association Officers the extent to which it has been under pressure to put the Federal plan into operation along the lines promulgated by the Washington, D. C., Bureau.

* * *

III—Position of the California Medical Association.

Through its constituted authorities, the California Medical Association has given full approval of the objectives involved, namely, to provide adequate obstetrical and pediatric care to wives and infants of enlisted men.

The California Medical Association objects, however, to giving approval to a mandatory and somewhat inelastic fee schedule for the professional work involved, as has been put forth by the Federal Children's Bureau in Washington, D. C.

That being the case, and the Federal Children's Bureau seemingly being unwilling to modify its plan in line with the resolutions adopted by the California Medical Association and American Medical Association (see the references above given), the Council of the California Medical Association, in its relation to the component County Medical Societies, is now in the position in which it must advise California Medical Association members as follows:

1. The California Medical Association has not given approval to the procedures for payment, as put forth by the Federal Children's Bureau.

2. The California Medical Association feels sure that everywhere throughout the State, members of the medical profession at all times will gladly meet their full obligations in the professional care of wives and infants of enlisted men.

3. The California Medical Association advises and requests its members to take such individual action as they may deem proper in every such maternity case, as may come under their respective observation and care.

Therefore, members of the California Medical Association, as individual physicians, are free to accept payments from either the California State Board of Public Health, or from a patient, or from both.

* * *

In case the California Medical Association policy as above outlined is changed, the component County Medical Societies will be notified.

Cordially and fraternally,
Philip K. Gilman,
Chairman of the Council of the
California Medical Association.

* * *

ITEM XII

Letter from American Medical Association Secretary West Concerning Obstetric Files:

(copy)

American Medical Association
535 North Dearborn Street,
Chicago, June 29, 1943.

Dr. George H. Kress
Secretary, California Medical Association
450 Sutter, San Francisco, California

Dear Doctor Kress:

Since you wrote me concerning a statement made by Doctor Daily of the Children's Bureau and since I replied to your communication, giving the best information that had been available to me, I have persisted in an effort to discover definitely whether or not Doctor Daily had had access to any figures prepared by our Bureau of Medical Economics pertaining to obstetrical fees. My persistence in the matter was due to a fear that it was possible that some one connected with the Bureau might have given Doctor Daily information without the Director of the Bureau knowing about it.

I have at last succeeded in turning up a letter addressed to Dr. R. C. Hood, Director of the Crippled Children's Division of the United States Department of Labor by a former employee of the Bureau of Medical Economics who left the services of the Association several years ago. That letter was written under date of March 11, 1937. We have also found a letter addressed to that employee by Doctor Hood. The letter addressed to Doctor Hood reads as follows: . . .

I think that the file referred to in this letter might have been found at an earlier date except for the fact that attention was focused on obstetrical fees.

It is to be remembered that the letter that emanated from our Bureau of Medical Economics was written on March 11, 1937, more than six years ago. It does not appear to me to be reasonable or fair to attempt to use any sort of fee schedule that may have been in effect in 1937 for the purpose of establishing fee schedules to apply in 1943.

I have diligently pursued this matter because I do not want to be unfair to any one. I had become convinced, after I received your last letter on the subject, that Doctor Daily must somehow have secured some sort of information through someone in the Association's office.

With most cordial good wishes, I am

Very truly yours,

Olin West, M. D.

* * *

ITEM XIII

Letter to Doctor Daily of Federal Children's Bureau from California Medical Association Secretary, Requesting Information Concerning Fee Schedules:

(copy)

California and Western Medicine

July 8, 1943.

Edwin F. Daily, M. D., Director
Division of Health Services
Children's Bureau of the U. S. Department of Labor
Washington, D. C.

Dear Doctor Daily:

Enclosed herewith find a memorandum on which you will find a copy of your own letter of June 30 addressed to the California Director of Public Health, Dr. Wilton L. Halverson, the same relating to the manner in which the grants-in-aid for medical, nursing and hospital care for wives and infants of enlisted men may be made.

I also enclose tear sheets of an editorial which appeared in the June issue of California and Western Medicine on page 314, under the caption "On Federal Children's Bureau Plan of Maternity and Infant Care for Wives and Infants of Men in the Armed Forces."

You will remember that when you conferred in San Francisco with the special California Medical Association Committee, of which Doctor Schaupp is chairman, and again when you conferred with the Southern Division of that Committee, you stated that the Federal Children's Bureau had availed itself of the information that had been given it by representatives of the American Medical Association concerning obstetrical fee schedules. Also, that you informed us that some three hundred fee tables which had been placed at your disposal by the American Medical Association, had a fee schedule of $35 for the complete service. At least, we understood that to be your statement. You will remember that our contention was that $35 did not cover the cost of service, and in the discussion it was brought out that the fee should not be less than $50 for the attending physician, and if the services of an obstetric specialist was necessary, up to $50 additional should be available, according to the nature of the service rendered.

* * *

May I ask you to check on the records of the Federal Children's Bureau and inform us, as promptly as possible, from whom in the American Medical Association you received the above information? Your Washington, D. C., records will no doubt give you this information.

We ask that you send us this information by air mail, because in whatever comments may be made concerning the matter, we desire to have explicit data.

Hoping to hear from you by return mail, and with all good wishes,

Cordially and sincerely yours,

George H. Kress, M. D.,
Secretary-Editor.

* * *

ITEM XIV

Letter from Indiana State Medical Association, Requesting Copies of California Medical Association Council Letters to California Medical Association County Medical Societies:

(copy)

Indiana State Medical Association

July 6, 1943.

Dear Doctor Gilman:

Thanks so much for the material which you have sent us giving the point of view held by the Council of the California Medical Association toward the care of wives and children of service men by the Federal Children's Bureau.

If possible, we would appreciate receiving 27 additional copies of this material so that we may send a copy to each of the councilors and Executive Committee and Maternal and Child Health Committee members of the Indiana State Medical Association.

Yours sincerely,

Thomas A. Hendricks,
Executive Secretary.

* * *

ITEM XV

Letter from Michigan State Medical Society to Its Members:

(copy)

Michigan State Medical Society

Lansing, Michigan, June 17, 1943.

Subject: Proposed Program of Obstetric-Pediatric Care for Wives and Infants of Enlisted Men in Michigan.

To Every Member of the
Michigan State Medical Society

Dear Doctor:

The Michigan State Medical Society has approved a plan for submission to governmental agencies re the above subject. This action was taken by the Executive Committee of The Council on June 16 and represented the first approval by the Michigan State Medical Society of any plan.

History. The study of plans for Michigan began on April 15 with consideration of proposals presented by the Bureau of Maternal and Child Welfare of the Michigan Department of Health. These were submitted by the State Society to the fifty-five county medical societies on May 4. By an overwhelming vote, the county medical societies disapproved them. As a basis for further negotiation, counter-proposals were prepared by a Study Committee of the Michigan State Medical Society Council on May 19. These were accepted by the Michigan Department of Health, and were submitted to all county medical societies for their opinion. The second poll, however, again disclosed a decided disapproval by a majority of the county societies.

Approved Plan. The plan definitely approved by the Executive Committee of the Council on June 16, based on advice received from county societies, is as follows:

Recognizing the responsibility of government to provide the usual comforts and necessities of life to wives and dependent infants of enlisted men in our armed forces, and consistent with the desires of our county medical societies as expressed in recent polls on this question.

This Committee recommends:

1. That federal grants be made direct to wives and dependent infants of enlisted men to provide the necessities of life, including medical care;

2. That such federal funds so paid to enlisted men's wives be used by the recipients as necessity requires;

3. That the Michigan State Medical Society should cooperate in a plan embodying the above principles; provided,

(a) That the program end six months after the termination of the present war;

(b) That the physician-patient relationship on a fee basis be maintained;

(c) That the details of operation and administration be worked out jointly by the Michigan Department of Health and a committee from the Michigan State Medical Society; that any future plans be subject to this same condition.

4. That a letter be sent to every county medical society and to every member of the Michigan State Medical Society requesting them to postpone participation until they receive notice from the Michigan State Medical Society that final details have been agreed upon.

A. M. A. Action. The Michigan State Medical Society action is in line with that taken by the House of Delegates of the American Medical Association, which met in Chicago, June 7-8-9, 1943.

Use of Government Blanks Not Authorized. Despite the fact that blanks have been distributed by the Michigan Department of Health to county society secretaries, their use is not authorized, and no approval has been given by the Michigan State Medical Society to any plan excepting the one outlined above. This is being transmitted to the Michigan Department of Health and as soon as it is accepted, every Michigan State Medical Society member will be notified through his county medical society.

Until an official acceptance of the Michigan proposal is received, no plan which may be attempted in Michigan will receive the coöperation of the Michigan State Medical Society.

In the meantime, you should continue to render the best medical care to the wives and dependent infants of soldiers, sailors, marines and those in the Coast Guard, and this can be done best through the physician-patient relationship, devoid of politics, governmental domination and red tape.

HR-2041, which would continue this federal program for the duration and six months after the war's end, is in the United States House of Representatives Labor Committee. The annual appropriation is set at $6,000,000.

Please write to your two Michigan Senators and your Congressman (list attached) AT ONCE, urging that they offer amendments to the bill to include the democratic principles outlined above (Nos. 1-2). Precedent for the direct grant to recipients has been established by the Social Security Board in providing recipients of Old Age Assistance with additional funds so that they may purchase necessary medical care from practitioners of their choice. No grant is made or should be made direct to the members of the medical profession.*

Thank you for contacting your Congressmen; this will help to counteract the gradual intrusion of State Rights.

2020 Olds Tower

Fraternally yours,

Michigan State Medical Society,
By L. Fernald Foster, M. D.,
Secretary.

ITEM XVI

List of United States Senators and Congressmen From California.

(In the list which follows, (R) means Republican and (D) means Democrat. Congress will be recessed during the months of July and August and will reconvene on September 14, after which Senators and Congressmen may be addressed at Washington, D. C.: the Senators in care of the Senate Office Building, and the Representatives in care of the House Office Building, Washington, D. C.)

Senators:

Hiram W. Johnston (R), Mills Tower, San Francisco.
Sheridan Downey (D), Atherton.

Congressmen:

First District: Clarence R. Lea (D), 719 North Street, Santa Rosa.

Second District: Vacant. Election pending.

Third District: J. Leroy Johnson (R), 1621 Argonne Drive, Stockton.

Fourth District: Thomas Rolph (R), 152 Twenty-Eighth Avenue, San Francisco.

Fifth District: Richard J. Welch (R), 978 Guerrero Street, San Francisco.

Sixth District: Albert E. Carter (R), 552 Montclair Avenue, Oakland.

Seventh District: John H. Tolan (D), 1749 Pleasant Valley Avenue, Oakland.

Eighth District: John Z. Anderson (R), San Juan Bautista.

Ninth District: Bertrand W. Gearhart (R), 857 M Street, Fresno.

Tenth District: A. J. Elliott (D), P. O. Box 134, Tulare.

Eleventh District: George E. Outland (D), 539 East Micheltorena Street, Santa Barbara.

Twelfth District: H. Jerry Voorhis (D), R. F. D. 1, San Dimas.

Thirteenth District: Norris Poulson (R), 317 South Commonwealth, Los Angeles.

Fourteenth District: Thomas F. Ford (D), 940 North Benton Way, Los Angeles.

Fifteenth District: John M. Costello (D), 5771 Valley Oak Drive, Hollywood.

Sixteenth District: Will Rogers, Jr. (D), 14253 Sunset Boulevard, Los Angeles.

Seventeenth District: Cecil R. King (D), 1152 West Eighty-Eighth Street, Los Angeles.

Eighteenth District: Ward Johnson (R), 790 Santiago Avenue, Long Beach.

Nineteenth District: Chet Holifield (D), 500 South Montebello Boulevard, Montebello.

Twentieth District: Carl Hinshaw (R), 3053 Lombardy Road, Pasadena.

Twenty-First District: Harry R. Sheppard (D), Yucaipa.

Twenty-Second District: John Phillips (R), 65 North Fourth Street, Banning.

Twenty-Third District: Ed V. Izac (D), 5380 El Cajon Boulevard, San Diego.

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* Editor's Note: For list of California Congressmen, see adjacent column. (Item XVI.)

ITEM XVII*

Table Showing Number of Births in California (by Counties and Cities) for Months of January, February, and March, 1943.

(a) (c) and (e) = Total All Births.

(b) (d) and (f) = Births to Wives of Enlisted Men.

	JANUARY 1943		FEBRUARY 1943		MARCH 1943	
	(a) Total All Births in California	(b) Births to Wives of Calif. Men in Armed Forces	(c) Total All Births in California	(d) Births to Wives of Calif. Men in Armed Forces	(e) Total All Births in California	(f) Births to Wives of Calif. Men in Armed Forces
CALIFORNIA	13,483	2,109	12,993	2,228	14,939	2,878
Alameda County†	42	....	39	1		4
Oakland	703	87	635	81		126
Alameda	87	20	59	13		12
Berkeley	205	25	186	28		27
San Leandro	1	....	....	....		....
Albany	69	4	80	6		7
Hayward	65	4	52	8		4
Piedmont	....	....	....	....		....
Alpine County	....	....	....	....		....
Amador County	6	....	5	....		....
Butte County†	57	10	60	6		7
Chico	17	6	15	3		8
Calaveras County	3	....	1	1		....
Colusa County	22	3	13	1		4
Contra Costa Co.†	25	3	37	2		6
Richmond	113	8	113	8		5
Martinez	38	3	26	6		8
Pittsburg	....	....	....	....		....
El Cerrito	....	....	2	....		....
Antioch	35	3	41	1		....
Del Norte County	6	1	7	....		2
El Dorado County	11	....	10	1		....
Fresno County†	131	21	127	15		27
Fresno	131	28	144	38		30
Coalinga	9	....	11	2		1
Glenn County	9	....	12	3		2
Humboldt County†	24	....	17	....		4
Eureka	34	8	48	....		7
Imperial County†	34	2	39	2		6
Brawley	51	2	41	4		4
Calexico	12	1	19	1		2
El Centro	48	7	14	1		6
Inyo County	25	....	30	1		....
Kern County†	139	26	133	33		41
Bakersfield	151	38	116	24		29
Kings County†	28	3	28	3		6
Hanford	46	11	51	12		17
Lake County	8	....	2	....		....
Lassen County	24	3	42	3		5
Los Angeles Co.†	485	62	573	70		105
Los Angeles	2,809	330	2,445	339		423
Alhambra	67	11	67	5		15
Long Beach	608	138	489	126		160
Pasadena	152	30	162	32		33
Pomona	59	8	58	11		6
Santa Monica	199	22	109	13		70
Glendale	244	18	309	46		29
Monrovia	14	1	16	3		2
Redondo Beach	3	1	2	....		....
South Gate	45	6	92	11		16
Torrance	73	12	27	1		10
Whittier	90	12	60	1		10
South Pasadena	1	12	....	6		16
Arcadia	....	....	....	....		....
Bell	51	8	95	7		11
Beverly Hills	....	....	....	....		....
Burbank	27	4	38	3		2
Compton	50	3	61	8		17
Culver City	34	4	66	6		9
Hawthorne	51	3	47	4		4
Huntington Park	46	12	70	8		13
Inglewood	96	9	97	10		13
Lynwood	13	2	20	3		4
Maywood	55	10	99	17		15
Montebello	2	0	....	0		....
Monterey Park	38	7	43	7		5
San Fernando	42	11	32	1		4
San Gabriel	1	....	3	....		....
San Marino	....	....	....	....		....
Azusa	2	....	8	....		1
Hermosa Beach	27	3	21	4		8
Gardena	....	....	2	....		....
Manhattan Beach	....	....	....	....		....
Madera County†	6	....	8	....		2
Madera	36	4	41	7		6
Marin County†	32	4	38	7		1
San Rafael	54	8	53	7		10
San Anselmo	....	....	....	....		....
Mariposa County	....	....	1	....		....
Mendocino County	39	3	31	4		1
Merced County†	94	13	82	14		19
Merced	16	2	28	7		7
Modoc County	33	1	24	....		3
Mono County	....	....	....	....		....
Monterey County†	111	15	124	29		35
Monterey	17	14	20	20		33
Pacific Grove	....	....	3	....		3
Salinas	38	9	39	12		14
Napa County†	23	2	17	4		5
Napa	35	....	50	2		3
Nevada County†	12	3	15	29		4
Grass Valley	16	5	9	....		2
Orange County†	45	2	54	5		4
Santa Ana	45	7	68	15		19
Anaheim	15	5	15	1		2
Fullerton	46	9	51	10		9
Orange	62	17	87	31		37
Placer County†	22	1	21	....		6
Roseville	1	....	1	....		....
Plumas County	12	....	15	....		....
Riverside County†	81	13	79	17		23
Riverside	125	37	135	48		64
Corona	15	2	18	3		....
Sacramento Co.†	11	2	12	3		2
Sacramento	379	64	378	74		92
San Benito County	14	1	15	2		1
San Bernardino Co.†	88	7	70	10		18
Redlands	29	6	27	4		9
San Bernardino	151	27	138	16		31
Ontario	11	1	11	....		....
Colton	2	....	10	1		....
Upland	68	7	42	6		10
San Diego County†	136	54	98	38		47
San Diego	565	160	621	170		208
Coronado	10	3	11	1		4
National City	81	6	68	7		10
Chula Vista	....	....	....	....		1
San Francisco Co.	1,088	212	1,103	249		309
San Joaquin Co.†	72	10	72	8		7
Stockton	138	21	124	19		25
Lodi	38	....	39	1		9
San Luis Obispo Co.†	42	19	31	18		31
San Luis Obispo	32	17	34	9		30
San Mateo County†	1	....	....	....		....
San Mateo	90	11	70	10		14
Burlingame	....	....	1	....		....
Daly City	....	....	....	....		....
Redwood City	6	....	9	....		2
South San Francisco	16	3	30	2		....
San Bruno	....	....	....	....		....
Santa Barbara Co.†	17	8	33	15		18
Santa Barbara	51	14	44	12		10
Santa Maria	40	11	58	20		7
Santa Clara Co.†	163	20	142	20		31
San Jose	115	15	117	10		19
Palo Alto	106	21	94	19		16
Santa Clara	1	....	1	....		....
Santa Cruz Co.†	15	6	5	3		3
Santa Cruz	33	3	27	5		10
Watsonville	35	9	33	6		12
Shasta County†	11	....	9	....		1
Redding	30	4	42	3		6
Sierra County	1	....	....	....		....
Siskiyou County	34	4	28	5		3
Solano County†	28	....	31	1		2
Vallejo	224	36	156	40		48
Sonoma County†	46	11	41	9		11
Petaluma	19	3	35	5		3
Santa Rosa	44	3	31	8		5
Stanislaus County†	55	2	47	5		3
Modesto	131	17	94	8		12
Sutter County	35	7	19	....		11
Tehama County	32	....	18	....		1
Trinity County	....	....	....	....		....
Tulare County†	91	7	123	16		13
Visalia	42	11	46	8		7
Porterville	13	4	31	3		8
Tulare	1	....	4	....		1
Tuolumne County	6	3	10	1		2
Ventura County†	32	3	24	3		8
Oxnard	33	7	45	8		4
Santa Paula	13	1	29	5		3
Ventura	34	9	15	6		14
Yolo County†	9	....	4	....		1
Woodland	26	5	24	7		4
Yuba County†	....	....	1	....		....
Marysville	25	4	23	8		8

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* This table was prepared from birth certificates filed with the State Department of Public Health. The selection of those that pertain to births in wives of service men was based upon the information provided under the item "occupation" on the certificate. The data are to be considered as an index only. There may have been more or fewer births to wives of men in uniform. This tentative list would indicate that approximately 17.5 per cent of all births are children of enlisted men. Whether the approximate percentage will continue is, of course, a question.

† Exclusive of cities listed, located in the county.

ITEM XVIII

Copy of a Statement of Policy by the Ohio State Medical Association Received by the California Medical Association on July 17, 1943.

(COPY)

Statement of Policy Adopted by the Council, Ohio State Medical Association, on July 11, 1943, Recommending Methods of Assisting Wives and Infants of Service Men to Obtain Financial Assistance for Medical and Nursing Services and Hospitalization in Ohio, and Opposing Plan Proposed by the Children's Bureau, United States Department of Labor.

In adopting this report, the Council made the following stipulations: (1) That the Committee on Public Relations confer with representatives of the Army, Navy, and Air Force relief agencies and offer assistance in working out a plan in accord with the recommendations contained in the report; (2) that State Director of Health Markwith and others who may have an interest in the question be invited to participate in such conferences; (3) that copies of the Council's action and the report be transmitted to Governor Bricker, the American Medical Association, all county medical societies in Ohio, and other state medical associations.

TEXT OF REPORT

At a conference held in Columbus on Saturday, June 19, the Committee on Public Relations and Economics discussed with Dr. R. H. Markwith, State Director of Health, a proposal suggested by the Federal Government, that there be established in Ohio a program to provide medical and hospital maternity and infant care for the wives and infants of enlisted men in the armed forces of the United States.

Such a program would be financed by the Federal Government through money allotted to the state by the United States Department of Labor. The State Department of Health, through its Division of Child Hygiene and other divisions, would administer the program in Ohio under general procedures, policies, and regulations promulgated by the Children's Bureau, United States Department of Labor.

Any wife of any enlisted man of the fourth, fifth, sixth, and seventh grades, irrespective of legal residence or of financial status, on application would be eligible to receive medical and hospital maternity care, including antepartum examinations, delivery, postpartum care and postpartum examination at the expense of the Federal Government under the proposed program. Children of such women under one year of age would be eligible to receive medical, hospital and nursing care, when ill, under the same conditions. In making application to receive such care for herself and child, or children, the wife of the enlisted man could select a physician and hospital willing to participate in the program, but the physician or hospital selected would have to certify that he or it will provide the services authorized at a stipulated fee set forth in the proposal, without additional payment from the patient or other persons.

A stipulated schedule of fees for the medical and hospital services, as well as nursing services, would be established. It is proposed that the inclusive rate to be paid a physician for complete medical services during the antepartum, labor and puerperium would be $35. The services would include antepartum examinations, delivery, postpartum care and postpartum examination approximately six weeks after delivery, and routine blood test for syphilis, hemoglobin determination, and urinalysis. Whenever the physician doing the delivery would not give antepartum care, he would be paid $25 for delivery and postpartum care. Whenever less than five antepartum examinations were made, the physician would be paid at the rate of $2 per examination. Five or more examinations would be paid for at the flat rate of $10 per case for antepartum care. Fees of $10 for consultation, $25 for minor surgery, and $50 for major surgery are proposed. Initial authorization for medical care for sick infants would cover a period not to exceed three weeks, and payments would be as follows: home or hospital visit, $3; office visit, $2, with the total amount authorized not to exceed $20. Provision for authorization for additional services for infants is incorporated in the proposal. The proposal also contains rules and stipulated fees for nursing services and hospitalization.

An appropriation of approximately $6,000,000 to finance this program throughout the entire country has been requested from the Congress.

* * *

Since the conference on June 19, your Committee has analyzed the following Reference Committee report on this subject, adopted without a dissenting vote by the House of Delegates of the American Medical Association in session on June 8, 1943, in Chicago: [Editor's Note: The American Medical Association resolution appears as Item VII in this series.]

* * *

Moreover, since the meeting on June 19, members of your committee and several members of the Council of the Ohio State Medical Association have conferred with Army officers charged with the responsibility of administering the program of a corporation known as Army Emergency Relief. Contacts have not been made as yet with officials of similar organizations functioning for the Navy and the Air Force.

Army Emergency Relief is a corporation formed in the District of Columbia in February, 1942. Its purpose is set forth in its certificate of incorporation as follows:

> The particular business and objects of said corporation shall be to collect and hold funds and to relieve distress of personnel of the Army of the United States and their dependents, including dependents of honorably retired or discharged and deceased personnel thereof, to provide for their education and to secure employment for honorably retired or discharged personnel and their dependents, and the dependents of deceased personnel.

General supervision of the activities of the branches and sections to which the administration of Army Emergency Relief is decentralized throughout the Army, and the control of funds, are important military duties delegated to commanders concerned. General Wallace, commanding general of the Fifth Service Command, is the officer controlling administration of the organization's program of relief and assistance in Ohio, Kentucky, West Virginia, and Indiana.

Army Emergency Relief and the American Red Cross have adopted a working agreement with respect to the handling of details in rendering assistance to the families of personnel of the Army. A substantial fund is in possession of Army Emergency Relief for carrying out its purposes, the money having been raised through special fund-raising activities, revenue from events of various kinds and miscellaneous contributions from patriotic and public-spirited citizens.

The funds of Army Emergency Relief may be used for financial assistance in the form of a loan, cash grant or relief in kind for families of Army personnel who are in need of assistance. Financial assistance for medical and nursing services and hospitalization is considered one of the most important phases of the program of the organization.

Officials consulted on this matter state that financial assistance for medical and nursing services and hospitalization is at present being provided to eligible families. It is their opinion that this program of assisting such families who are in need of medical and nursing services and hospitalization, including obstetrical services of wives of soldiers and medical care for the children of soldiers, can, and should, be expanded. They welcome the assistance and coöperation of the medical profession of Ohio in making this program of greater practical value. Obviously, the funds of Army Emergency Relief are not unlimited as to amount, but it is felt that the organization is in a position to meet the needs of deserving cases if accorded real coöperation on the part of physicians, nurses, and hospitals.

* * *

Based on the conference referred to and after a careful study of the questions which have been discussed, *your* *committee makes the following recommendations for consideration of the Council:*

The Ohio State Medical Association is fully aware of the fact that it is the obligation of the medical profession to see that all persons residing in Ohio, whether temporarily or permanently, receive necessary medical care, including the wives and children of personnel of the armed forces. Although we have reason to believe that this obligation will be met irrespective of the ability of an individual to pay for such services, the Association makes a special plea to its members to see that the traditional policy of the medical profession that all persons, regardless of financial status, shall be provided with an opportunity to utilize the advantages of modern scientific medicine is complied with at this time.

The Association realizes that it may not be possible for the medical profession to carry out the above recommendation if there should be a large number of cases ineligible to receive assistance under existing public assistance programs. Therefore, it is conceded that some plan to assist the medical and nursing professions, and hospitals, may be needed in the near future.

Therefore, this Association should coöperate with Army Emergency Relief in furthering its program of providing financial assistance for the families of Army personnel needing such assistance for medical and nursing services and hospitalization. The same offer of coöperation should be extended to similar agencies of the Navy and the Army Air Force. These agencies were established for the purpose of assisting families of personnel of the armed forces in providing necessities of life, including medical and nursing services and hospitalization. They have funds which would appear to be sufficient to meet current requests for assistance and a considerable number of additional requests. If this procedure can be worked out satisfactorily—and we believe it can—there will be no necessity for the use of public funds or the maintenance of a Government-controlled medical program to furnish medical care for the wives and children of service men.

It is recommended that Army Emergency Relief and similar agencies of the Navy and Air Force in providing financial assistance to the families of service men so they may obtain necessary medical and nursing services and hospitalization should make such assistance available in the form of a loan or cash grant. This will enable the wife to make her own arrangements with respect to fees, services, etc., with a physician of her own choice for herself or children.

In event the funds of the relief agencies of the Army, Navy or Air Force are found inadequate to provide assistance for all worthy cases, we would then favor the adoption of a plan under which the Federal Government would provide financial assistance by making a stated cash allotment for medical and nursing services and hospitalization to the wife and children of enlisted men on the basis of need. *This would be similar to the present arrangement under which cash allotments are provided for the maintenance of dependents of service men. If such a plan should become necessary, we feel that it would be desirable for this Association to bring the matter to the attention of Ohio's representatives in the United States Congress and urge them to sponsor legislation to provide the necessary funds and distribution of such funds as suggested.**

* * *

The Association is opposed to the proposal sponsored by the U. S. Children's Bureau and urges the State Director of Health of Ohio not to put such plan into effect in Ohio for the following reasons:

1. There appears to be no need for the Children's Bureau program, as we are confident that the relief agencies of the Army, Navy, and Air Force can provide adequate financial assistance for needy cases.

2. The Children's Bureau plan would provide assistance in the form of medical and nursing services and hospitalization irrespective of need.

3. It would not provide the wife of an enlisted man with the unrestricted freedom of choice of physician, nurse, or hospital for herself and children, as the choice could be made only from among those willing to participate in a governmentally administered medical, nursing and hospital program.

4. It would establish a medical, nursing and hospital program under control of the Federal Government, even though it would be administered directly by the State Department of Health, as the latter would be subjected to the policies and regulations of the Children's Bureau at Washington.

5. It would preclude assistance on the part of relatives and friends of the families of service men as well as voluntary relief and welfare agencies, any or all of whom might be willing, and in a position, to provide assistance in worthy cases.

6. It would establish a mandatory, inelastic maximum fee schedule for professional fees and hospitalization, regardless of the merits of individual cases and circumstances involved.

7. It would place a third party, namely, a federal agency, virtually in control of medical services and inject a third party into the relationship between physician and patient.

8. It would establish the base for a much larger federally controlled medical care program to cover all classes of citizens, not only the families of men in the armed forces.

9. It would have a tendency to reduce the quality of the services rendered—a tendency ever present in bureaucratic programs which place administrative controls and red tape and occasionally political interference, between the producer and recipient of professional services.

Chemical Casualties: Lecture Teams

California State War Council, through the Emergency Medical Service, Morton R. Gibbons, M. D., Chief of the Northern Sector, has organized teams to give lectures on Chemical Casualties. Information follows:

California State War Council
Sacramento, California
995 Market Street
San Francisco, 3

June 29, 1943.

Dear Doctor Kress:

First let me thank the California Medical Association for the coöperation its staff gave our clerk in checking the membership lists of the county medical societies. This was a great help to us in connection with preparations for the course of instruction in "The Prophylaxis, Care, Pathology, and Treatment of Chemical Casualties," circular relative to which is attached.

This circular, together with an announcement giving details of time and place for each county (sample of San Mateo announcement enclosed) will be sent by the county societies to all members. This office will mail to all nonmembers of each county society.

As explained in the circular, these courses will be given by teams from the faculties of the medical departments of the University of California and Stanford University who were prepared in the subject at the school held in San Francisco in mid-May. This school was addressed by specialists from the O. C. D, U. S. Army, U. S. Navy, and the National Research Council. Much material not yet published—the latest experience, thought, and usage in war gases—was received.

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* A list of California congressmen appears under Item XVI, for convenience of California Medical Association members.

All physicians are urged to attend. The schedule as arranged to date follows:

San Joaquin County—Thursday, July 8, Clubrooms, Medico-Dental Building.

San Mateo County—Tuesday, July 13, Mills Memorial Hospital.

Fresno County—Tuesday, July 13. Awaiting notification of place.

Santa Clara County—Friday, July 16, Medico-Dental Building, Auditorium.

Marin County—Thursday, July 15, San Rafael City Hall.

Monterey County—Thursday, July 15, Colton Hall, Monterey.

San Francisco County—Sunday, July 11, 9 to 1 o'clock, War Department Theater, Presidio.

Sacramento County—Date not set as yet.

Sincerely,
(Signed) Morton R. Gibbons, M. D.,
Chief, Emergency Medical Service
Northern California Sector.

* * *

Northern California Sector
EMERGENCY MEDICAL SERVICE
Division of Civilian Protection
CALIFORNIA STATE WAR COUNCIL

To Members of the Medical Profession:

Members of the faculties of the medical schools of the University of California and of Stanford University will visit your city to give you the latest information concerning "The Prophylaxis, Care, Pathology and Treatment of Chemical Casualties." Much of the information will not be available from any other source. It is new—*the result of the latest investigations!* Instruction will include a sound film. Such an opportunity should not be missed! The accompanying notice will give you time and place. You are urged to attend.

Morton R. Gibbons, M. D.,
Chief, Emergency Medical Service,
Northern California Sector.

* * *

SAN MATEO COUNTY MEDICAL SOCIETY
NOTICE OF SPECIAL MEETING

Time, Tuesday, July 13, 7:45 p. m.
Place, Mills Memorial Hospital, San Mateo.
Subject, "Prophylaxis, Care, Pathology and Treatment of Chemical Casualties."

Please see the enclosed circular letter from Morton R. Gibbons, M. D., Chief of the State Emergency Medical Service, Northern Sector, for details of this important meeting presenting speakers from the medical schools of Stanford University and the University of California who have been especially prepared on this subject. Descriptive sound film is included and each registrant will be provided with a syllabus to which notes from the lecture may be added.

Each physician in attendance will be required to register.

Logan Gray, M. D., *Secretary,*
San Mateo County Medical Society,
57 Fourth Avenue, San Mateo.

* * *

Northern California Sector
EMERGENCY MEDICAL SERVICE
Division of Civilian Protection
CALIFORNIA STATE WAR COUNCIL

July, 1943.

To Members of the Medical Profession of San Francisco:

Under the sponsorship of the State Emergency Medical Service and of the San Francisco County Medical Society, special arrangements have been made to present an instruction team made up of members of the faculties of the medical schools of the University of California and of Stanford University, on the subject:

"The Prophylaxis, Care, Pathology and Treatment of Chemical Casualties."

Time, Sunday, July 11, 1943, 9:00 a. m. to 1:00 p. m.

Place, War Department Theatre, Presidio, San Francisco. (Inquire at Presidio gate, Lombard Street entrance, for directions to the War Department Theatre.)

Instruction team: Troy C. Daniels, M. D.; David A. Rytand, M. D.; Leslie L. Bennett, M. D.

Field exercise directed by Lieutenant Colonel Grant Jenkins, Chemical Warfare Service, U. S. Army.

Instruction will include an illustrative sound film.

Much of the information to be given is available from no other source. It is new—the result of the latest investigations!

All physicians in San Francisco are invited—and *urged*—to take advantage of this opportunity to prepare for service in this field, should need arise.

Morton R. Gibbons, M. D.,
Chief, Emergency Medical Service,
Northern California Sector.

Henry Gibbons, III, M. D.,
Chief, Emergency Medical Service,
San Francisco War Council.

"Victory Depends On Me."—At a recent gathering of the California Board of Medical Examiners it was the Editor's privilege to hear Walter K. Wilson, Major General, U. S. A., upon request, recite a poem he had written, "Victory Depends On Me." The sentiments expressed in the verses suggest their suitability for placement in this department of the "California Medical Association Committee on Participation of the Medical Profession in the War Effort." Verses follow:

VICTORY DEPENDS ON ME

I am a Soldier, tried and true,
Who fights, in order to subdue
The Axis foe across the sea—
For Victory depends on Me.

I am a fighting Sailor lad
Who sails in weather, good and bad,
To sink our foe upon the sea—
For Victory depends on Me.

I am a bold and brave Marine
Who lands on shores I've never seen
To fight and smash the enemy—
For Victory depends on Me.

An Aviator, bold, am I
Who knocks the Axis from the sky
And sinks their ships upon the sea—
For Victory depends on Me.

I am a steady Working Man
Who works to build the best I can
The ships, the planes, the guns, you see—
For Victory depends on Me.

Americans, let's do our part
And work and work with all our heart.
Let each one say with certainty—
That Victory depends on Me.

God, our Father, to Thee we pray
To guide us on our stormy way.
Inspire, and make each one to see—
That Victory depends on Me.

W. K. W.

U. S. Medical Genius Saving War Victims

Chicago, June 7.—An inspiring epic of American military medicine in saving the lives of the heroes who have expelled the Axis armies from North Africa was unfolded at the opening of the American Medical Association's annual session in Chicago today.

In the battles to come, the American combatants will receive such medical care as the world has never before known, according to Dr. Norman T. Kirk, Surgeon General of the United States Army, Brig. General Dr. Fred W. Rankin, and Dr. H. H. Shoulders, speaker of the Association's house of delegates.

Death Rate Lower

The death rate among all battle casualties, General Kirk said, including wounded and ill, in Tunisia, has been between 2.5 and 3.5 per cent. This refers to "evacuation hospitals," where the soldiers are given their first treatment before any are sent to "base hospitals."

In the first World War, the comparable death rate varied between 15 and 18 per cent.

General Kirk said that the low death rate and the very low incidence of infections in the wounds was accomplished by three measures: use of blood plasma, excellent surgery required to clean the wounds, and use of sulfa drugs.

Capital Service

The American people who have helped in building up the blood plasma banks have rendered capital service to the soldiers, General Kirk pointed out.

Improved methods of making plaster casts, which allow better blood circulation, are being developed. The new drug penicillin, most powerful of germ killers known to science and still in the experimental stage, is not available for general use.

Doctor Rankin pointed out that, henceforth, American organized medicine will have to harmonize State controlled medicine with private medicine.

Doctor Shoulders also emphasized that the need of the hour is not for "medical politicians," but for "medical statesmen."

Said he:

"The whole future of our profession will be determined not by research, however important its contributions might be, but by the character of the medical statesmanship to be employed."—San Francisco *Examiner*, June 8.

Office of War Information Sets Total Casualties Since Outbreak at 91,644.—Casualties of the armed forces since the outbreak of the war now total 91,644.

The Office of War Information said tonight this includes 16,696 dead; 21,828 wounded; 31,579 missing; and 21,541 prisoners of war.

* * *

Army casualties total 64,621, divided as follows:

Killed, 8,533; wounded, 17,094; missing, 21,046; prisoners of war, 17,948. Of the wounded, 6,268 have returned to active duty or have been released from hospitals. The Army casualties include 12,506 Philippine scouts. Of these, 481 were killed, 743 wounded, and the remainder are presumed to be prisoners of war.

* * *

Navy casualties totaled 27,023 as follows:

Dead, 8,163; wounded, 4,734; missing, 10,533; prisoners of war, 3,593.

* * *

Marine Corps—Dead, 1,688; wounded, 2,447; missing, 987; prisoners of war, 1,737; total, 6,859.

* * *

Coast Guard—Dead, 182; wounded, 22; missing, 157; prisoners of war, 1; total, 362.—Los Angeles *Times*, July 4.

Spas for War Casualties.—Serious consideration should be given a resolution passed by the recent legislature memorializing Congress to start acquisition of some of California's mineral springs as locations for convalescent hospitals for invalid soldiers of the present war.

This state is blessed with over four hundred mineral springs of high potential curative value, but only a few ever have been developed and even those not extensively. None of the famous spas of Europe or the eastern United States have waters superior to those available in California. For years there has been agitation for their development, but the State's interests have been on other things and this marvelous resource has gone neglected.

The war's inevitable casualties now bring their importance to the fore as a national asset. Army and Navy medical authorities will have thousands of convalescents to care for, many of whom will be of the type to be greatly benefited by mineral-water treatments. Where could hospitals with these facilities be better situated than in California with its matchless climate as an added therapeutic agency?

The League for Development of California's Mineral Springs, with headquarters here, is starting an aggressive campaign for recognition of this opportunity. It deserves all possible public support.—Editorial in San Francisco *News*, May 28.

Medical Graduates—Many Will Go Into Services

Only 20 per cent of the medical graduates each year can now be spared for care of civilians. The others will go into the military medical corps as long as the war lasts.

This prospect was sketched to the house of delegates of the American Medical Association in Chicago by Dr. James E. Paullin, of Atlanta, the Association's new president.

The yearly total of new civilian physicians he estimated at about 1200. To this he added about 600 who are being retired each year from military service. Against this the doctors who are left, mostly men over 45, are dying at the rate of 2500 a year.

This leaves a deficit of about 700 a year. To meet this, and the big shortage due to nearly half the active doctors already in military service, Dr. Paullin said plans should be made now for better use of the older physicians who have not been very active in medical practice.

It is the hope of organized medicine to have one doctor for each 1500 persons in the United States. This compares with an average of two to four per thousand in many areas, and is much better than some rural communities which have seldom or never had more than one doctor for 2500 to 3000 persons.—Redwood City *Tribune*, June 12.

Selective Service Will Check On Doctors to Determine Deferments

Washington, June 22.—Selective Service disclosed today that local boards have been instructed to check closely on the work of men asking or already granted occupational deferment as resident doctors in hospitals.

It was explained officially that information received by headquarters indicated that, despite the army's "great need" of doctors for its units, there are a "large number of young doctors" serving as residents in "many hospitals throughout the United States."

The boards were told not to defer resident doctors who "are engaged in the furthering of their medical education or are under the strict supervision of and dependent upon another doctor or other doctors in the work performed."

Deferment may be granted, however, if the doctors are "engaged in work involving independent diagnosis and treatment of patients subject only to the ordinary hospital staff supervision."—Sacramento *Bee*, June 22.

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† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Doctors desiring to go into the Army may have their papers prepared and receive orders for physical examination from the Officer Procurement Service, 328 Flood Building, San Francisco, in charge.

Affiliated Hospital Units of the Office of Civilian Defense: General Rules

One hundred ninety-one hospitals and medical schools have been invited by the Surgeon General of the U. S. Public Health Service to organize affiliated hospital units of the Emergency Medical Service of the U. S. Office of Civilian Defense. The invitation was extended to so large a number of civilian hospitals because each unit will be called upon for service only in a war emergency affecting its own region. Units will be activated only in event of a grave military disaster affecting the civilian population or military personnel in the area in which the parent hospital is located. Activation of a unit will take place only upon recommendation of the State Chief of Emergency Medical Service and the Office of Civilian Defense Regional Medical Officer, subject to certain limitations imposed by the Surgeon General and the Chief Medical Officer of the Office of Civilian Defense and by agreements with the invited hospitals.

Because these limitations may not as yet be understood by all physicians and hospitals which have been invited to participate in the Emergency Medical Service, the rules governing activation of affiliated units are set down as follows:

1. Members of the staffs of affiliated units are commissioned in the inactive reserve of the U. S. Public Health Service, generally with the rank of Passed Assistant Surgeon, Surgeon, or Senior Surgeon (equivalent, respectively, to Army ranks of Captain, Major, or Lieutenant Colonel). They will remain on inactive status for the duration of the war unless urgent need for their services should arise in their region because of an air raid or other grave wartime disaster. When activated under such circumstances, these officers will receive the pay and allowances of officers of equivalent grades in the armed forces.

2. The two specific purposes for which a unit may be activated are:

(*a*) For duty in an emergency base hospital to which civilian casualties and other hospitalized patients must be transferred because a community is under enemy attack and one or more of its hospitals must be evacuated.

(*b*) For temporary duty to assist the armed forces at the time of an extraordinary military emergency which may temporarily overtax local military hospital facilities. Such temporary assistance will be provided in or near the locality in which an affiliated unit has been organized. The period of emergency assistance is expected to be of short duration and will last only until the Surgeon General of the Army can send in additional medical officers or until he can distribute the excessive load of sick and wounded to military hospitals in other parts of the country. Affiliated units are organized primarily for civilian protection and are not to be used to staff military hospitals as they expand to meet increasing medical requirements of the Army.

3. Since affiliated units are organized by the Medical Division of the Office of Civilian Defense as part of the Emergency Medical Service of their States, they will be expected to provide aid only in their own or neighboring States. Their members will not be detached for duty in other parts of the country nor, in accordance with the terms of their recruitment, will they be activated for any other duty except those listed in paragraph 2 of this statement.

4. A unit organized from the staff of a teaching hospital of a medical school will not be called unless the hospital itself must be evacuated or unless there is no unit from a non-teaching hospital to meet the emergency need.

5. The period of obligation for service will cease at the termination of the present national emergency; the Surgeon General will accept resignations of members of Units 6 months after cessation of hostilities.

6. A commission in the inactive reserve of the U. S. Public Health Service does not prevent a member of an affiliated unit from entering the armed forces; resignation will be accepted for this purpose.

7. Members of affiliated units may wear the authorized lapel buttons which indicate that they have enlisted for emergency service. They are not to wear the uniform until called to active service and need not purchase a uniform unless the possibility of active service is imminent. Uniforms will not be required for brief periods of active service.

Because it is essential for civilian protection, the organization of affiliated units has received approval of the Board of Trustees of the American Medical Association. For the same reason, the Directing Board of the Procurement and Assignment Service has authorized "essential" physicians to accept positions in affiliated units.

* * *

Emergency Base Hospitals Under Office of Civilian Defense (Medical Division): California Units

California ultimately will have between 34 to 37 affiliated base hospital units.

REGION IX

(Corrected to date of June 9, 1943.)

CALIFORNIA:

San Diego County General Hospital, San Diego.

Mercy Hospital, San Diego.

Collis P. and Howard Huntington Memorial Hospital, Pasadena. (Unit is substantially complete.)

University of Southern California School of Medicine, Los Angeles.

College of Medical Evangelists, Loma Linda. (Satisfactory progress has been made.)

Los Angeles County Hospital (Medical Unit), Los Angeles.

Hospital of the Good Samaritan, Los Angeles. (Unit is substantially complete.)

Cedars of Lebanon Hospital, Los Angeles. (Unit is substantially complete.)

St. Vincent's Hospital, Los Angeles. (Unit has not been formed.)

Presbyterian Hospital-Olmstead Memorial, Los Angeles. (Satisfactory progress has been made.)

Queen of Angels Hospital, Los Angeles. (Satisfactory progress has been made.)

Santa Barbara Cottage Hospital, Santa Barbara.

Ventura County Hospital, Ventura.

Sacramento County Hospital, Sacramento. (Unit has not been formed.)

Highland-Alameda County Hospital, Oakland.

Samuel Merritt Hospital, Oakland. (Unit has not been formed.)

University of California School of Medicine, San Francisco. (Unit is substantially complete.)

Stanford University School of Medicine, San Francisco. (Unit is substantially complete.)

St. Luke's Hospital, San Francisco.

St. Mary's Hospital, San Francisco. (Unit has not been formed.)

Sonoma County Hospital, Santa Rosa. (Satisfactory progress has been made.)

General Hospital of Fresno County, Fresno. (Satisfactory progress has been made.)

San Bernardino County Charity Hospital, San Bernardino.

San Joaquin General Hospital, French Camp, San Joaquin County. (Unit is substantially complete.)

Santa Clara County Hospital, San Jose. (Unit is substantially complete.)

Monterey County Hospital, Salinas. (Unit is substantially complete.)

The following hospitals have been invited recently to form units:

San Francisco:
St. Francis Hospital
St. Joseph's Hospital
Children's Hospital

Los Angeles:
California Lutheran Hospital

Long Beach:
Seaside Hospital
Community Hospital

Bakersfield:
Kern County General Hospital

* * *

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U. S. N. The Senior Medical Officer is Capt. Philip K. Gilman, U. S. N. R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone: EXbrook 3386, Local 46.

The Naval Office of Procurement for the southern section of California is in charge of Admiral A. Johnson, U. S. N. The Senior Medical Officer is Captain John C. Ruddock, U. S. N. R. The office is located at 411 West Fifth Street, N. W. Corner of Hill, Los Angeles. Telephone: MIchigan 8641.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Lack of Enough Hospital Facilities in Southern California Held "Dangerous"

Lack of hospital facilities in the Los Angeles area was described as "dangerous" by Monsignor Thomas J. O'Dwyer yesterday at a public hearing conducted by the Downey subcommittee of the Senate Military Affairs Committee.

Half Enough

The Committee, meeting in the State Building, heard O'Dwyer, Director of Charities and Hospitals, Archdiocese of Los Angeles, estimate that only "one-half the hospital beds needed are available."

"For a city playing a vital rôle in the war effort and located on an exposed coast line to be so inadequately prepared is dangerous," Monsignor O'Dwyer said.

Stressing need for more hospital facilities, he said that in the Los Angeles nonprofit hospitals there is a total of only 2,396 beds and that last April 1,217 persons were denied admittance to the hospitals.

Other parts of the county are even more overcrowded than the city, he said.

Nearly at Capacity

He estimated that on the basis of standards set up by the American Medical Association and American Hospital Association, at least twice the number of beds now available should be available.

Hospitals in this locality are operating at between 93 and 100 per cent capacity every day, Monsignor O'Dwyer said.

Dr. Walter Treadway, medical director in charge of the United States Public Health Service Relief Station in Los Angeles, said the problem was particularly serious in the San Fernando Valley and Huntington Park areas and far short of perfect in San Bernardino County, San Diego County, and Los Angeles County generally.—Pasadena *Post*, June 17.

Hospital Bed Ratio in Los Angeles Is Alarming

Just how critical the shortage of hospital beds in Los Angeles is can readily be seen from a comparison of the number of beds in our nonprofit hospitals with those in other cities.

Such a comparison shows Los Angeles to be at the bottom among other major cities, with 1.4 adult beds in its nonprofit hospitals per 1,000 population. The American Hospital Association recommends three beds for 1,000 population for industrial cities like Los Angeles.

Detroit, approximately the same size as Los Angeles, has 2.5 beds per 1,000, while in St. Louis the figure is 4.1. In Philadelphia the beds per 1,000 number 4.2. San Francisco is far better off than we, with 3.7.

The factor contributing most to the shortage of beds in local hospitals is the great increase which has occurred in our population during the last decade and the inability of our institutions to increase their capacity to keep pace with the population growth.

During the last five years, while our population was growing by 285,000, only 264 beds were added in our nonprofit hospitals. To have accommodated the persons represented in this increase in population alone, 855 beds would be needed.

Another factor contributing heavily to the tremendous increase in the hospital load is the popularization of hospital service. This has come about largely through public education. Not too many years ago the average person knew little about hospitals and looked upon them with a feeling of both awe and fear. Today most people are familiar with the various types of care which our hospitals can render and eagerly seek this service when in need of it. National Hospital Day and intelligent public relations programs have played an important rôle in acquainting the public with our hospitals.

Medical Care

American Medical Association Tackles a Controversial Problem

The American Medical Association today created a new council to plan for better medical care throughout the nation.

The Council is authorized to study medical plans of all sorts, to suggest policies and to report these to the state and county medical societies which would have the job of putting them into effect.

The new council has no power to go beyond suggesting, but neither has any American Medical Association Council, now or in the past. The actions of these councils, however, always have strongly influenced the practice of medicine throughout the country, and the new council's position promises to be powerful.

Criticism in Past

Criticisms have been made of the American Medical Association for years for failing to propose a plan for improved medical care for the public at large. The new council is taken as an answer to these criticisms.

Recent developments within the American Medical Association, indicating more than one hundred medical group prepayment plans, indicate that instead of one single plan for medical care, there are likely to be several. Each section's needs are different, the doctors find, and each will require modifications in any plan that might be best in some other section. . . .

The Council was established by the American Medical Association House of Delegates, the supreme body of organized medicine, and was instructed to get to work immediately. The Council is responsible only to the House of Delegates.—San Francisco *Chronicle*, June 10.

Hospital Association in Suit Against State Commission

Suit was filed on June 12 by the Pasadena Hospital Association, Ltd., against the California Employment Commission, seeking to recover the $4,039.28 paid for the first quarter of 1943 as unemployment insurance contributions, plus a 6 per cent interest on that sum.

The hospital sets forth that it is in many ways a philanthropic and nonprofit institution, that some of its departments are agencies of the Community Chest, that many of its facilities and dispensing clinic are provided at cost, and in some instances without charges, and that it has paid the unemployment contributions under protest.—Hollywood *Citizen-News*, June 12.

The Syphilis Rate—Forty-Seven in Each One Thousand

Washington, June 14 (AP).—Congress learned today that in the examination of men, aged 21 through 35, for the armed services, 47.7 of each 1,000 were found to have syphilis, and that the prevalence among Negroes in one Southern State ran to 405.9 in each 1,000.

The figures, based on a study of the first two million selectees examined in forty-four States, were given to the House Appropriations Committee by the Public Health Service.

Dr. Thomas Parran, Surgeon General, said rejections ran to 46,000 in each 1,000,000 men on account of syphilis and 15,000 of each 1,000,000 due to gonorrhea infection.—San Francisco *Chronicle*, June 15.

COUNTY SOCIETIES[†]

CHANGES IN MEMBERSHIP

New Members (45)

Alameda County (6)

Anderson, Bruce M., *Oakland*
Cieri, Joseph D., *Oakland*
Collen, Morris Frank, *Oakland*
Delanty, Ella Katherine, *Oakland*
Vedder, Edward B., *Oakland*
Ward, Willis A., *Berkeley*

Fresno County (1)

Wheeler, Dorothy Fraser, *Fresno*

Lassen-Plumas-Modoc County (3)

Benedict, Hans, *Westwood*
Bleiberg, Donald Joseph, *Quincy*
Weiss, Ernest, *Westwood*

Los Angeles County (18)

Bishop, Clifford O., *Los Angeles*
Brickey, Vernon P., *Long Beach*
Crum, John David, *Beverly Hills*
Dillon, Richard, *Los Angeles*
Elgin, James Carroll, *Los Angeles*
Fox, Gertrude, *Glendale*
Gowdy, Ralph A., *Santa Monica*
Haley, Edgar R., *Santa Monica*
Irvine, Wendell C., *Beverly Hills*
Levine, Boris E., *Los Angeles*
Lindenauer, David, *North Hollywood*
Mortensen, Martin A., *Los Angeles*
Shields, Jane, *Los Angeles*
Snyder, Monica Harnden, *North Hollywood*
Stevens, Carl F., *North Hollywood*
Tietz, Esther Bogen, *Arcadia*
Townsend, Guy Walter, *Hollywood*
Weinberger, Willard William, *Long Beach*

Orange County (1)

Carlson, Verne W., *Orange*

San Bernardino County (1)

Gladen, Ralph G., *Walla Walla, Washington*

San Francisco County (14)

Banks, Harry B., *San Francisco*
Campion, Gwendolyn M., *San Francisco*
Dickson, Owen C., *San Francisco*
Diller, Theodore, *San Francisco*
Freed, Solomon Charles, *San Francisco*
Hughes, Clara L., *San Francisco*
Klinghoffer, Kalmen A., *San Francisco*
Lange, Jack D., *San Francisco*
Madlen, Jr., Leo Smith, *San Francisco*
Rourke, Anthony J. J., *San Francisco*
Saunders, William W., *San Francisco*
Shaw, William Francis, *San Francisco*
Traut, Herbert F., *San Francisco*
Yellen, Daniel, *San Francisco*

San Luis Obispo County (1)

O'Reilly, Francis F., *San Luis Obispo*

Transfers (8)

Cohen, Peter, from Santa Barbara County to San Francisco County.

Graham, Harold L., from San Luis Obispo County to Santa Clara County.

Lewis, Joseph D., from Santa Barbara County to Yuba-Sutter-Colusa County.

Mollath, A. L., from Santa Barbara County to San Diego County.

Nicholas, C. Z., from Santa Barbara County to San Diego County.

Patton, William G., from San Bernardino County to Los Angeles County.

Wayland, Raymond T., from Los Angeles County to Santa Clara County.

Wood, Charles M., from Placer-Nevada-Sierra County to Sacramento County.

In Memoriam

Brown, Thomas Hartwell. Died at Woodland, May 17, 1943, age 61. Graduate of the University of Toronto Faculty of Medicine, 1906. Licensed in California in 1910. Doctor Brown was a member of the Butte-Glenn Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Carroll, Robert Lide. Died at Los Angeles, June 7, 1943, age 48. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1926. Licensed in California in 1932. Doctor Carroll was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Currie, Albert Harlan. Died at Los Angeles, April 19, 1943, age 57. Graduate of the Bennett College of Ecl. Med. and Sur., Chicago, 1911. Licensed in California in 1911. Doctor Currie was a member of the Los Angeles County Medical Association and the California Medical Association.

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Deacon, George. Died at Pasadena, May 24, 1943, age 87. Graduate of the Rush Medical College. University of Chicago, 1885. Licensed in California in 1887. Doctor Deacon was a retired member of the Los Angeles County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

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Petersen, Henry Christian. Died at Stockton, May 17, 1943, age 67. Graduate of the University of Illinois College of Medicine, Chicago, 1905. Licensed in California in 1906. Doctor Petersen was a member of the San Joaquin County Medical Society and the California Medical Association.

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Priestley, William Fletcher. Died at Oakland, May 29, 1943, age 58. Graduate of the Cooper Medical College, San Francisco, 1912. Licensed in California in 1912. Doctor Priestly was a member of the Alameda County Medical Association and the California Medical Association.

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Rethers, Charles Albert. (Lt., M. C., U. S. N. R.) Died near Tia Juana, Mexico, May 26, 1943, age 40. Graduate of Creighton University School of Medicine, Omaha, 1933. Licensed in California in 1935. Doctor Rethers was a member of the San Francisco County Medical Society and the California Medical Association.

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Robbins, Arthur Colby. Died at Ensenada, Baja California, April 21, 1943, age 40. Graduate of the College of Medical Evangelists, Loma Linda, 1923. Licensed in California in 1923. Doctor Robbins was a member of the Orange County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

[†] For roster of officers of component county medical societies, see page 4 in front advertising section.

CALIFORNIA PHYSICIANS' SERVICE[†]

Beneficiary Membership

Commercial (May, 1943)		46,000
Rural Health Program		5,000
War Housing Projects (approximate)		40,342
Marin	5,488	
Los Angeles	5,811	
San Diego	13,320	
Vallejo	14,723	
San Francisco	1,000	
Total		91,342

California Physicians' Service has given notice to the Regional Office of the Federal Public Housing Authority that it is our intent to cancel the existing contract of the medical plan in housing projects unless satisfactory readjustments can be made to put the plan on a sounder financial basis.

This has become necessary because of the revealing information contained in the statistical analysis of the first six months of operation. These figures show an overwhelming cost in relation to obstetrical service (35 per cent of total gross income). They also show a cost much greater than anticipated for surgery in relation to "back log" or neglected conditions.

Just what specific adjustments will be made, it has not been agreed upon at this time. Careful consideration is being given to the elimination of parts of obstetrical service and elective surgery, increase in rates and the effect of these on the membership. We believe that a satisfactory solution can be obtained.

In the interim the load of carrying the program will fall upon the shoulders of the medical profession. Since the California Physicians' Service has never had any capital other than the support of the profession, we must necessarily call upon this resource during the coming months.

In our discussions to date, it is clearly evident that the Housing Authority *will* have medical care in the housing projects. They sincerely desire that this be provided through organized medicine of this state. However, this is not the only means by which such service may be obtained.

California Physicians' Service has been through many administrative crises before, which have gradually been solved. We believe from the pure business point of view we can also solve this one. (We have caught the symptoms of danger very early.) This emergency program of the medical profession must be looked upon as a contribution to the war effort. Its beneficial effect on the morale and health of thousands of migrant war workers is beyond dispute.

We who are doing our best to solve the terrific problems of the most complicated nature must assume that the profession wants this program to continue. We also must assume that the profession is supporting us, and will continue to support us as we go through another violent phase in the history of California Physicians' Service.

(Copy of Report of June 22 to Professional Members)

California Physicians' Service
153 Kearny Street
San Francisco, California
743 South Grand View Street
Los Angeles, California

Dear Doctor:

Due to the large number of requests from California Physicians' Service professional members, we are enclosing a folder which describes our surgical and hospital coverage for employed groups whose annual family income does not exceed $3,000. We wish to thank the many professional members who have given these folders to their patients. Through your help, we have recently been able to place this service in several large groups. If you desire, we shall be glad to send you more of these folders.

There is a great deal of discussion between the administrative members, trustees of California Physicians' Service, and the Council of the California Medical Association regarding the many problems that are beginning to make themselves felt in the State as the result of the shortage of doctors and the increase in population. All of these discussions have taken on added urgency because of the recent introduction of the Wagner Bill for compulsory health insurance on a national basis. It is to be noted that the introduction of the Wagner Bill was strategically timed to antedate the recent meeting of the American Medical Association. At this meeting, for the first time, there has been official recognition of the place that medical service plans are taking in anticipation of such inevitable legislation. To this end the House of Delegates of the American Medical Association established a council to study and evaluate existing plans in the United States. It is to be pointed out to you that the two most significant plans in the United States are Michigan Medical Service and the California Physicians' Service.

Financial operations for the month of April are as follows:

Dues collected	$51,028.82
Professional member registration fee	80.00
	51,108.82
Cost of administration	11,993.00
Available for April services	39,115.82
X-ray and laboratory on hospitalized patients	3,079.44
Available for remaining professional services	36,036.38
20,086.6 units of service at $1.75	35,151.55
Transferred to Unit Stabilization Fund	884.83
Previous balance in fund	29,622.30
Total Unit Stabilization Fund	$30,507.13

A. E. Larsen, M. D.
Executive Medical Director.

June 22, 1943.

Venereal Disease Prophylaxis: Among Women

Dr. J. C. Geiger, Director of Public Health, announced the opening of the San Francisco City Separate Women's Court, located in the Health Center Building at 135 Polk Street, San Francisco. The Separate Women's Court is established to meet the problem of the professional prostitute, streetwalker, and other sexually promiscuous women who are arrested by the Police Department.

Prior to the opening of the Separate Women's Court these women were housed in the women's section of the San Francisco City Prison. During their confinement first offenders were placed with habitués and frequently with other criminals, thus affording an excellent opportunity for promoting the maladjustment of the first offender.

Note: For comment concerning California Physician's Service and Mannix Report, see Minutes of California Medical Association Council and Editorial Department.

[†] Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings[†]

California Medical Association. Place and date of the 73rd Annual Session, to be held in 1944, to be announced later.

* * *

American Medical Association. Place and date of 1944 Annual Session to be announced later.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts[*]

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a. m., under the title "Your Doctor and You."

In July, KFAC will present these broadcasts on the following Saturdays: July 3, 10, 17, 24 and 31.

The Saturday broadcasts of KECA are given at 10:45 a. m., under the title "The Road of Health."

"Doctors at War":

Radio broadcasts of Doctors at War by the American Medical Association in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy are on the air each Saturday at 2 p. m., Pacific War Time.

Pharmacological Items of Potential Interest to Clinicians[*]:

1. *Reviews:* Really hot, says M. Shimkin, is J. P. Greenstein's survey of tumor enzymology (*J. Nat. Cancer Inst.*, 3:419, 1943). Then there's N. J. Berrill's study of malignancy in relation to organization and differentiation, and A. Dorfman's review of pathways of glycolysis (*Physiol. Rev.*, 23:101, 124, 1943). Also note C. Monge's survey of chronic mountain sickness (*Ibid.* p. 166). W. Raab reviews the pathogenic significance of adrenalin and its relatives for heart muscle. (*Exp. Med. & Surg.*, 1:188, 1943). H. C. Clark goes over recent work on prophylaxis and treatment of malaria (*J. Nat. Malaria Soc.*, 1:113, 1943). J. N. Davidson offers brief summary with big bibliography of "wound hormones" (*Edin. Med. J.*, 50:70, 1943). A. Lipschitz summarizes his studies on endocrine aspects of antitumoral autodefense (*Rev. Canad. Biol.*, 2:92, 1943). L. Brouha & Co. survey work on "step test" to measure physical fitness for hard muscular labor (*Ibid.*, p. 86). L. W. Shaffer reports on present status of intensive arsenotherapy of early syphilis (*Ven. Dis. Info.*, 24:108, 1943). E. W. Thomas and G. Wexler do likewise (*Arch. Dermat. Syph.*, 47:553, 1943).

2. *Symposia:* Pleasant one on impetigo (*Lancet*, 244: 544, 547, May 1, 1943). Important one on scientific proof and relations of law and medicine (*Ann. Int. Med.*, 18: 445-697, 1943). Interesting one on stuttering in remarkable new journal *The Nervous Child* (2:79, 1943).

3. *Shock:* In elaborate studies on traumatic shock, J. Fine, A. Seligman & Co. find that oxygen has no value in hemorrhagic shock (*J. Clin. Invest.*, 22:265-305, 1943). F. L. Engel, M. G. Winton and C. N. Long show that hemorrhagic shock causes liver and tissue injury from anoxia with increased proteolysis and lactate and pyruvate accumulation (*J. Exp. Med.*, 77:397, 1943). G. F. Kamen (*Proc. Soc. Exp. Biol. Med.*, 52:363, 1943) suggests that lipoid breakdown products like acrolein may have some causative relation to shock. J. P. Levinson and H. E. Essex (*Ibid.*, p. 361) show that peripheral vasoconstriction occurring in shock is not dependent on an intact nerve supply. P. L. Mollison discusses hemolytic transfusion reactions (*Brit. Med. J.*, 2:529, May 1 and 8, 1943).

4. *A Few Books:* C. C. Thomas (Springfield, Ill.) publishes C. L. Gemmill's *Physiology in Aviation*, an inexpensive and brief item. J. B. Sumner and G. F. Somers issue *Chemistry and Methods of Enzymes* (Academic Press, N. Y.). G. L. Walls writes on *The Vertebrate Eye and Its Adaptive Radiation* (Cranbrook Inst. Science, Bloomfield Hills, Mich.). J. H. Masserman discusses *Behavior and Neurosis* (Univ. Chicago). Oxford issues E. J. Bowen's *Chemical Aspects of Light.* C. C. Thomas Springfield, Ill.) also publishes J. A. Reyniers *Micrurgical and Germ-Free Methods: Their Application to Experimental Biology and Medicine.* And here's another salute to Herbert Evans—for whose 60th birthday the University of California publishes a special volume of scientific tribute. Stanford Press will issue A. C. Reed's *Tropical Medicine.*

5. *Alia:* H. A. McGuigan's ideas on mass hysteria hide a pertinent point (*J. Asso. Am. Med. Col.*, 18, 182, 1943). Why have scientific periodicals—read *Life!* And did you note the article about our L. L. Lumsden in Satevepost? Of course, development of resistance to penicillin is noted

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[†] In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

[*] County societies giving medical broadcasts are requested to send information as soon as arranged.

[*] These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

(L. H. Schmidt and C. L. Sesler, *Proc. Soc. Exp. Biol. Med.*, 52:353, 1943). M. R. Sapirstein finds glutamic acid controls ammonium ion enzymatically in brain and thus may control epileptic convulsions (*Ibid.*, p. 334). C. Gutierrez-Noriega notes metrazol convulsions due to summation of local stimuli augmenting direct action on the drug on motor neurones: there is no evidence for a convulsant center (*J. Neuropath. Exp. Neurol.*, 2:132, 1943). J. J. Pfiffner & Co. isolate antianemic factor from liver in crystalline form (*Science*, 97:404, 1943). B. C. McIvor and S. P. Lucia describe method of getting anti-Rh serum (*Proc. Soc. Exp. Biol. Med.*, 52:293, 1943).

Doctors of Medicine as Others See Them.—During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest.

The above item, with some quotations, appeared in CALIFORNIA AND WESTERN MEDICINE (July issue, pages 108-109; October, pp. 269-270; November, pp. 287 and 331-332; January, pp. 49 and 50; February, pp. 92-93; April, pp. 255-257; and May, pp. 305-308. More recent items follow:

THE DOCTOR IS RATIONED

Recently Dr. Maxwell Lapham of the War Manpower Commission announced in Washington that during this year approximately 12,000 physicians would be called into the armed forces, leaving about 80,000 to care for accidents and ailments on the home front. This, he ventured, would reduce the ratio of doctors to one for every 1,500 persons, "the outer limit of safety from the standpoint of public health."

Some communities, nevertheless, already find themselves beyond that limit of safety, and everywhere doctors are scarce and their time precious. The problem is by no means separate from the public responsibility. Action must be taken to ease the strain, action by individuals, as a safeguard to personal health and as a war time obligation.

First it is imperative at once to impose on ourselves a voluntary rationing of the doctor's time as far as our own demands on him are concerned. An average adult can learn to identify danger signs that actually require a doctor on the spot as well as he can recognize the slight symptoms he can handle himself. As a matter of fact, few medical ailments cannot afford to wait a short time for diagnosis, according to the eminent Dr. Thomas Masters, who points out, too, that fears rise inordinately at night, necessitating many useless calls when hard working physicians desperately need their rest.

Finally, for the sake of public health and the health of our own loved ones, it is wise, for the duration of doctor rationing at least, to learn and remember the common rules that keep human beings well, and to keep our nerves steady and common sense in command if unpreventable illness does strike.—Sacramento *Daily Recorder*, May 12.

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MATCH THIS RECORD

More than 28 000 physicians volunteered their services without pay to the Selective Service boards. More than 40,000 physicians gave up their careers in civilian practice to serve with the armed forces. This directing board of the Procurement and Assignment Service for Physicians, and its many representatives throughout the nation, serve without one cent of remuneration. The hundreds of physicians on the consultant committee of the Division of Medical Science of the National Research Council, and in the office of Research and Development, contribute time and income without one cent of remuneration. Throughout the nation, thousands of doctors furnish countless services in connection with civilian defense, without one cent of remuneration. It would be interesting to know what other trade or profession can match this record of public service.

And yet proposals are made to throw American medicine into the political arena, and level it off to the standards prevailing in European countries where experiments in socialized medicine have utterly failed to produce the health records and benefits to the general public which are the rule rather than the exception in the United States. Fortunately for the people of this country, such efforts seem to have failed.

American medicine is marching ahead unselfishly and scientifically in its determination to maintain for our armed forces and the people at home the highest medical standards in the world—not for this year, or next year, but for every year.—Hanford *Sentinel*, May 24.

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FACTS ABOUT SOCIALIZED MEDICINE

We believe it would, indeed, be profitable for those who advocate governmental direction of medical aid and who know little or nothing about socialized medicine, to stop and consider the plan as now operated in England. By and large, the medical profession of the United States have done and are doing a fine job. It was our privilege several years ago at an editorial round-table discussion, to refute statements made by Professor May of the University of California, who spoke on the subject at Stanford University.

To substantiate our thesis we wish to cite a few facts from England that eloquently and factually relate the story of compulsory health insurance. Under the British system of health insurance a physician has a panel of 1,000 to 2,500 patients at $2.25 each per year. He may have to see 100 patients a day. Frequently as many as sixty persons must be seen in his office in two hours—two minutes per patient, including paper work. There is no time for adequate treatment. If a panel physician keeps patients waiting too long, they report him to his superiors. Unlike American physicians, the panel physician in England rarely has the time or the energy to study, engage in research, attend medical meetings or take refresher courses.

It is easy to see why doctors oppose schemes to emasculate the American medical system. It has its shortcomings, but fundamentally it is the most efficient, far-reaching system yet devised. Infinitely more important, it is a system which inspires initiative and progress. Within its framework doctors are free individuals. Tomorrow, next week, next year, as the future rolls into the present, new techniques and new cures will come from the imaginative, probing minds of American medical men. It would be calamitous to freeze medicine into a compulsory socialistic mold that would kill the souls of these men.—Isleton *Journal*, May 21.

* * *

THE RATIONING OF OUR DOCTORS

Reading in news columns of the fiftieth anniversary of the organization of the Riverside Medical Society calls to mind the fact that this year approximately 12,000 physicians of the nation would be called into the armed forces, leaving about 80,000 to care for accidents and ailments on the home front.

This would reduce the ratio of doctors to one for every 1,500 persons, "the outer limit of safety from the standpoint of public health."

California Tuberculosis Association

The California Tuberculosis Association is the state organization which administers in California the general policies and principles of the National Tuberculosis Association. The California Tuberculosis Association is a federation of sixty-two local associations; it is democratically controlled by representation proportionate to the funds raised by each of the locals. The California Tuberculosis Association receives 16 per cent of the gross seal sale for the first $10,000 raised, 11 per cent for the next $10,000, and 7½ per cent for all over $20,000.

Each local association receives in return many of the services offered by the California Tuberculosis Association. The state office acts as a clearing house for supplies and for ideas. One of the main functions of its staff is to give assistance to the smaller local associations in this state which do not have sufficient funds to maintain trained tuberculosis health workers.

All local associations operate under "Authorized Forms of Tuberculosis Work" as approved by the National Tuberculosis Association. Permissible activities are health education, coöperation with other agencies, research and study, case-finding demonstrations, and organization and administration.

American Medical Association Will Meet in San Francisco in 1946.—Chicago—AP—San Francisco yesterday was selected for the 1946 meeting of the American Medical Association, the war permitting.—Sacramento *Union*, June 10.

Lane Medical Lectures.—The Lane Medical Lectures are now generally recognized as an international institution. The imposing array of illustrious lecturers from many foreign lands, as well as this country, shows this rather conclusively. This result happily fulfills the vision of the founder, the late Dr. Levi Cooper Lane, also the founder of Cooper Medical College, now the Stanford School of Medicine.

It was Doctor Lane's idea to bring leading medical scientists from Europe, where great advances were then being made, to California and the West rather than to send Western physicians there. Above all, he believed the personal contact and inspiration of these leaders was most valuable for his colleagues and his institution. Not only has this aim been amply fulfilled, but the high quality and the influence of the lectures as sources of information and of provoking thoughts and ideas for research and discoveries is attested by numerous references to them in the literature of medicine.

In a period close to fifty years since the lectures were established, almost every branch of medical science has been represented by outstanding experts, discoverers, or investigators. The Stanford medical faculty, always mindful of the aims and desires of the founder, intend to maintain these lectures on the highest plane possible as a means of promoting the value and influence of medical science everywhere.

The last eight series of the Lane Medical Lectures have been published by the Stanford University Press, Stanford University, California.—The Stanford *Colophon*, April, 1943.

United States Naval Hospital at Mare Island Entertains Sonoma, Solano, Marin and Napa County Medical Societies.—The United States Naval Hospital at Mare Island, through the courtesy of the Medical Officer in Command, Capt. J. P. Owen (MC), U. S. N., and Capt. Frank W. Ryan (MC) U. S. N., Executive Officer, on Tuesday evening, June 8, 1943, had as guests members of the Sonoma, Solano, Marin, and Napa County Medical Societies.

This conjoint dinner, at which colleagues who are attached to the United States Naval Hospital were the hosts, has become an annual event and is looked forward to with increasing interest by all who have had the opportunity to attend.

It is particularly interesting to note that this expression of coöperation comes from physicians who are in military service, the extension of courtesy being to colleagues who are in civilian practice.

An excellent dinner was served, after which the meeting was adjourned to the theatre building, where the scientific program was presented by staff members of the Naval Hospital.

In the program were listed the names of the following staff members.

Capt. J. P. Owen (MC) USN, Medical Officer In Command.

Capt. Frank W. Ryan (MC) USN, Executive Officer.

Capt. R. I. Longabaugh (MC) USN (Ret.), Gas and Security Officer.

Capt. C. G. Hines (MC) USN, Chief of Psychiatric Service.

Commander E. F. Holman (MC)V(S) USNR, Chief of Surgery.

Commander E. L. Markthaler (MC)V(S) USNR, Chief of Medicine.

Commander J. W. Thompson (MC)V(S) USNR, Chief of Eye, Ear, Nose and Throat.

Lt. Comdr. P. R. Yeeks (MC)V(S) USNR, Chief of X-ray Service.

Lt. Comdr. B. E. Konwaler (MC)V(S) USNR, Chief of Laboratory Service.

Lt. Comdr. J. W. McPheeters (MC)V(S) USNR, First Lieutenant (Maintenance Officer).

Lieut. E. F. Aron (MC) USN, Assistant Administrative Officer.

Lieut. J. R. Ayer (HC) USN, Hospital Corps Officer.

Lieut. (jg) G. E. Harris (HC) USN, Commissary Officer.

Chief Pharmacist G. R. Gibson (HC) USN, Personnel Officer.

Pharmacist A. V. Watson (HC) USN, Property and Accounting Officer.

The program of the evening follows:

Demonstration of Patients with Stader Splints.

Film-Application of Stader Splint.

Demonstration of Patients with Pylon and Artificial Leg—Dr. Douglass Toffelmier.

Demonstration of Patients with Wax Treatment for Burns—Dr. Ralph G. Pendleton.

"The War Neuroses"—Dr. F. H. Smith.

Films:

(*a*) Excision of Brachial Aneurism—Dr. E. F. Holman.

(*b*) Hospital Views, Presentation of: War Decorations. The Surgeon General's Visit.

Doctor Toffelmier presented a series of patients on whom the Stader splint had been used. Different types of the splint were shown, its advantages as regards rotation, lengthening and tilting being pointed out, and its modes of applications indicated by demonstration and also later on the screen.

This splint is not yet available on the open market, but at the Mare Island Hospital has been much used. Doctor Toffelmier explained that with the splint it is necessary perhaps to set more of the fracture by hand, but once the fragments are in place and the splint applied, the portion involved is in solid position. The splint is probably better adapted for hospital than for field service. Even in secondary closures, the splint has been found to be of much value. With its use, there is much greater possibility of the patient becoming either fully or partially ambulatory.

Doctor Toffelmier also presented patients to demonstrate the use of Pylon and artificial legs. Mention was made of the adaptability of this procedure even when stumps are short. Method of securing good stumps was described.

Dr. Ralph G. Pendleton discussed in some detail a wax treatment for burns which has been developed in good part at the Mare Island Hospital. He referred to local and general reactions in relation to burns of different degrees and methods of cleansing, and procedures in preparation for the use of the wax combination which is sprayed on. A special advantage of the procedure is that it does not need a trained person to apply it. The hours saved in care of burn cases is very great. The treatment can precede or follow other procedures and the application of the wax not only alleviates pain and local distress, but promotes early motion of the parts involved, and aids in the prevention of contractures. The mixture is quite inexpensive.

Patients and films completed the demonstration.

Dr. F. H. Smith, the third speaker, gave an illuminating address concerning war neuroses, calling attention to some of the new types of such that have come under observation due to the present-day methods of warfare. It is not surprising that when men are subject to bombardment day and night, with little opportunity for rest and all the ordinary routine of living done away with, and under conditions made more complicated by rain, heat and diseases such as dysenteries, malaria, they crash up mentally and physically. In some places, as at Guadalcanal, these conditions were intensified by a feeling of helplessness and the impression that they would be left alone and could not be rescued.

The symptoms were briefly mentioned and tentative figures in incidence of such breakdowns were given.

Also discussed was the prognosis in many of these patients, not only as regards return to normal mental and physical health, but in relation to capacity to again take up the responsibilities of military life, either full or limited, or civilian activities.

The program was completed by the presentation of films taken at the Mare Island Hospital, the same being interspersed with comments by the Medical Officer in Command, Capt. J. P. Owen, who pointed out the importance in an institution such as the Mare Island Hospital, to maintain morale and proper esprit de corps.

Tribute Paid to Doctor Zeiler.—Approximately 100 of his colleagues and friends honored Dr. A. Herman Zeiler, pathologist, at a dinner at the University Club sponsored by the executive medical board of the California Hospital last night.

Dr. Benjamin H. Hager, chairman of the staff of the hospital, was chairman of the meeting, and Dr. E. J. Cook, emeritus chairman of the staff, was toastmaster. Speakers included Doctors John W. Grossman, Howard F. West, Donald G. Tollefson, E. Vincent Askey and E. H. Wiley.

Doctor Zeiler started a laboratory here in 1911. In 1917 he became pathologist for the California Hospital.*—Los Angeles *Examiner,* June 8.

New Drug—Penicillin.—*The Journal of the American Medical Association* recently described penicillin, a newly used drug, as "far superior to any of the sulfanilamides" in treating infected wounds and burns.

Because of production difficulties, the Journal said, use of the drug will be limited almost entirely to the armed forces for the present.

The drug was first used by the Army six weeks ago when arrangements were made by the surgeon-general for clinical tests at Bushnell General Hospital, Brigham City, Utah.

"Results have been so encouraging," the Journal reported, "that plans now are in process for undertaking similar wound studies in ten general army hospitals and venereal disease studies in six. A similar though less extensive plan will be pursued by the navy."

Penicillin, which was discovered in 1929 by Alexander Fleming in London, is made from a mold, the Journal said. —Bakersfield *Californian,* May 20.

New Treatment Is Found for Burns.—A new and simple paraffin wax spray for treatment of burns sustained by military personnel was described today in the *Journal of the American Medical Association.*

Lt. Com. Ralph C. Pendleton, U. S. N. R., in an article discussing the treatment which he developed describes the method as "the paraffin wax open air treatment."

Doctor Pendleton explained:

"The present global war has resulted in so many serious burns occurring en masse that surgeons face a challenge to devise some simple method of treatment which will be effective, humane and simple enough for application by inexperienced assistants to overworked doctors and nurses."

The treatment consists in spraying medicated paraffin on the burned parts of the body, leaving the injured sections free of cumbersome bandages and open to the air.

Using this method there is no need for cleansing or pruning the dead tissues from the burned area before applying the spray.

No gauze is needed because the wax itself serves as a dressing, according to Doctor Pendleton. It checks pain promptly, the author said, and, because it permits early free motion of injured members, prevents numerous deformities that have resulted from other methods of early treatment.

Riverside Doctors Celebrate Fiftieth Anniversary.—Fiftieth anniversary of the organization of the Riverside Medical Society was commemorated on May 13 at a special meeting of the society for which about 100 members and guests gathered for dinner at Victoria Country Club.

Dr. Bon O. Adams acted as master of ceremonies during the program, which included reading of minutes of the society for May 13, 1893, by Dr. F. A. Veitch, and reminiscences about older members of the organization by Dr. William Wallace Roblee. Tribute to Doctor Roblee and the late Dr. C. Van Zwalenburg was voiced by Dr. T. A. Card, their associate.

Gold-headed canes, traditional gifts in recognition of long service to the society, were presented to Doctor Adams, Dr. C. W. Girdlestone and Dr. R. R. Root of Corona. Doctor Roblee had received his some time ago. Dr. W. E. Gardner made the presentations.

Special guests were Dr. Clarence G. Toland of Los Angeles, who told of his father, Dr. M. R. Toland, pioneer San Jacinto physician; Dr. Fred D. West of Beaumont and Dr. Alan Bramkamp of Banning, who spoke on Dr. John C. King, early member of the society who is now past 90 and resides in Pasadena and from whom a letter to the society was read; Mrs. W. B. Payton, Mrs. Arthur L. Brown, Mrs. W. B. Wells and Mrs. H. J. Wickman.

Dr. H. W. Naeckel was chairman of arrangements for the anniversary fête which closed with gay nineties skits presented by the Community Players.—Riverside *Press,* May 14.

Weil's Disease (Leptospirosis).—The Los Angeles City Health Department recently brought to the attention of the physicians of Los Angeles two recent deaths from Weil's Disease of the icterohaemorrhagiae type, contracted in the city of Los Angeles. The department bulletin stated that there are two types of Weil's Disease: the first is caused by L. icterohaemorrhagiae and is contracted probably from the feces and urine of rats; the second, L. canicola, is contracted from dogs and cats. It has also been reported as being contracted from infected pork. The incubation period is approximately ten days. The organism usually enters through skin abrasions, although the gastrointestinal tract, nasal mucous membranes, and the conjunctiva have all been suggested.

The onset is acute, with a high continuous fever during the first few days. There is headache, vomiting, diarrhea, and frequently a dry tongue with characteristic red edges. The conjunctiva is injected, the throat is frequently sore, rheumatic pains are common, and jaundice occurs in about 50 per cent of the cases. There may be a relapse at the end of three weeks. The mortality in the United States is about 12 per cent.

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* Many friends of Doctor Herman Zeiler will regret to learn that his death took place on the morning of Thursday, July 15.

He was buried from the Church of the Recessional in Forrest Lawn Cemetery on Monday, July 19, 1943.

When jaundice occurs, differential diagnosis usually has to be made between Weil's Disease, Catarrhal Jaundice, Acute Yellow Atrophy of the Liver, and Yellow Fever. When jaundice does not occur, the differential diagnosis becomes much more difficult. Diagnosis is made by blood serology and by isolation of the organism from urine and blood. Blood serology does not become positive until around the third week.

Sulfa drugs and neosalvarsan are of no proved value in treatment. Sodium bismuth tartrate, intravenously, has been successful in some cases, as has been the use of hyperimmune horse serum. The control consists of the proper care of swimming pools, adequate rat proofing, and the proper handling of urine from recovered patients.

Nurses Fight for More Pay.—The State Nurses' Association, recently authorized by its members to act as their collective bargaining agent with hospitals, has called for a United States Conciliation Service mediator to help it in its wage-increase demands on California hospitals.

The nurses want $155 a month base pay for registered nurses doing regular staff work. They said some now get as low as $115.

If the conciliator is unable to effect an agreement, the case is to go to the War Labor Board for an order, association officials said.

Address by Commander Emile Holman.—An address on "Changing Patterns in Medical Care" was delivered by Com. Emile Holman, M. C., chief surgeon at the Mare Island Naval Hospital and head of the Stanford department of surgery, at the annual dinner and initiation of the Stanford chapter of Phi Beta Kappa on May 26.

Dinner was served at 6 p. m. in the Stanford Union. Initiation of the seventy-five new members and election of officers was conducted at that time. Commander Holman spoke at 8 p. m. in the auditorium of the Education Building.

Commander Holman is an alumnus of Stanford, where he was elected to Phi Beta Kappa in 1911. He holds degrees from Stanford, Oxford and Johns Hopkins universities. He was a Rhodes Scholar at Oxford from 1914 to 1917 and has taught at Johns Hopkins, Harvard, Western Reserve and Stanford.

A member of the American College of Surgeons, he is the recipient of various medical honors, including the Medaille de Roi Albert in 1918, when he was a member of the Committee for Relief of Belgium.—Palo Alto *Times*, May 26.

Board Names Health Officer of Los Angeles County.—Dr. H. O. Swartout yesterday was officially appointed County Health Officer by the Board of Supervisors to succeed Dr. W. L. Halverson, who resigned the position to become director of the State Department of Public Health.

Doctor Swartout has been acting County Health Officer for the last six months while Doctor Halverson was on a leave of absence which expired last Tuesday.

Prior to becoming acting head of the Health Department, Doctor Swartout was director of the bureau of preventable diseases in the department. He has had a wide experience in the medical field and holds a degree from Yale University as doctor of public health.—Los Angeles *Times*, June 18.

On Civilian Defense.—Operations Letter No. 131 from James M. Landis, Director of the Office of Civilian Defense, Washington, D. C., issued June 12, 1943, under the caption "The Health Department in Civilian Protection." Operations Letter No. 131 has been issued to clarify health department functions in civilian protection. Other material outlining technical operations of the health department in event of air raids or other wartime disaster is under preparation.

Infantile Paralysis.—A project which will make The National Foundation for Infantile Paralysis the only complete central, authentic source of information on infantile paralysis in the world was recently announced by the Foundation.

A complete bibliography of all scientific literature that ever has been published pertaining to infantile paralysis is being compiled by the Foundation, and is expected to be ready for publication in book form in the early part of 1944. The first volume will contain a record of all scientific material on poliomyelitis published in the world up to the end of 1943. Subsequently, the data will be kept up to date by publication of annual supplements. Brief abstracts of the more important articles will be included in the bibliography to be published by the Foundation, 120 Broadway, New York.

American Board of Otolaryngology.—An examination of applicants for the American Board of Otolaryngology will be held in Los Angeles on February 2, 3, 4, 5, 1944. Applications must be filed with Dr. Dean M. Lierle, Secretary-Treasurer, University Hospital, Iowa City, Iowa, by November 1, 1943.

Visiting Nurses Ease Medical Care Shortage.—As a step toward combating the threat to public health feared because of the induction of thousands of doctors and nurses into the armed forces, the American Red Cross has launched visiting nurse programs in several war-swollen communities on the Pacific Coast.

Reports on their pioneering indicate success and is already rewarding this effort to halt the possible "slow deterioration" in the nation's health that has been forecast as the probable result of acute shortages in medical care.

Vallejo, California, and Bremerton, Washingon, rapidly growing naval construction centers, are outstanding examples of communities facing serious problems as the result of simultaneous loss of medical power and multiplication of population. In both cities, employment of visiting nurses by the Red Cross has sharply reduced the demands upon remaining physicians and hospital facilities. These nurses in many cases can make patients' calls upon doctors unnecessary or at least greatly reduce the number. They work in close coöperation with welfare and other official agencies.

In Spokane, Wash., and twenty-four smaller communities in the Mid-West and Pacific area, similar programs have been launched.

Nurse Shortage Acute, Part-Time Jobs Offered.—The shortage of nurses at the General Hospital has become so acute that part-time jobs to housewives and other women not employed full time have been offered, to work as nurse auxiliaries, it was announced on June 6 by Arthur J. Will, Director of County Institutions.

The half-time employment will pay $65 to $70 per month on a per diem basis, it was said. Women between the ages of 18 and 45 who have had a high school education are eligible to apply.

fficers and Members of the Council — California Medical Association*

aptain P. K. Gilman
hairman of the Council

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Pasadena

Hartley F. Peart, Esq.
General Counsel

George H. Kress, M. D.
Editor
Secretary-Treasurer

Mr. John Hunton
Executive Secretary

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* These photographs appeared on the place cards of the Dinner to President William R. Molony, Sr., at the seventy-second annual session of the California Medical Association, in Los Angeles, May 2, 1943.

MEDICAL JURISPRUDENCE[†]

HARTLEY F. PEART, ESQ.
San Francisco

Malpractice: Sufficiency of Evidence to Sustain Judgment for Plaintiff; Degree of Care Required of a Specialist

In *Sansom* vs. *Ross-Loos Medical Group,* 57 A.C.A. 547, decided March 8, 1943, by the California District Court of Appeal, the facts were these:

When the plantiff was fourteen years old his arm was broken as the result of a collision between the bicycle on which he was riding and an automobile. He was taken by his parents to the defendants for the purpose of having the broken bone set and treated. This medical service was rendered by several different doctors at different times. They were all members of, or employees of, a partnership group of medical men operating a clinic. The humerus was broken in the upper part of the arm in such manner that the two broken ends of the shaft slipped past each other.

The first physician to treat the boy placed him in bed in the hospital, and reduced the fracture by pulling the two broken pieces of the humerus apart to overcome the overlapping, and then adjusting the broken ends in apposition to each other so that they might grow together again. The arm was encased in a plaster cast and a system of wires and weights and pulleys were attached so that a pull was exerted on the arm. After some time spent in the hospital, the boy was sent home with his arm in a plaster cast, but still under the supervision of the defendants. The first physician who treated him was followed by another, and then by the chief of the clinic. In the words of the court: "All of these doctors were orthopedists."

As time went on there was difficulty in getting the two broken ends of the bone to grow together again. Eventually, a union ensued, but in such manner that the broken ends united at an angle, leaving the bone between the elbow and the shoulder with a crook in it. Also, the plaintiff's arm was one-half inch shorter than it had been before it was broken.

An action for malpractice was commenced, and a verdict was rendered in the sum of $8,500 against the defendant co-partners, all of whom were physicians and surgeons. On appeal to the district court, the judgment for the plaintiff was affirmed.

On appeal, the sufficiency of the plaintiff's evidence to sustain a finding of negligence on the part of the defendants was questioned, but the court found very meager evidence to be sufficient. A medical expert had testified at the trial on behalf of the plaintiff to the effect that a physician or orthopedic specialist in charge of a case, who failed to have x-ray pictures of plaintiff's arm taken frequently enough to keep the attending physician advised of the progress of the healing, and who failed to take steps to correct the progress of angulation of the union, and who also failed to maintain traction and a cast on the arm for a sufficient length of time, did not exercise that degree of care and skill required of the average physician practicing in the same locality. The testimony by this one witness was held sufficient to charge the defendants with negligence and a breach of their duty as physicians to exercise the care and skill ordinarily used by physicians practicing in the same community.

In addition, the court ruled that a physician who holds himself out as a specialist in a particular field is bound to possess a higher degree of skill in that field than the ordinary practicing physician. That is to say, in the instant case where the defendants held themselves out as orthopedists specializing in procedures of the type required by the plaintiff, they were bound to meet a higher requirement as to the extent of knowledge and skill they must possess and use than the ordinary practicing physician would be required to meet. More particularly the court ruled that the defendants were bound to have and use the same degree of knowledge and skill ordinarily possessed and used *by other specialists and experts of the same type* practicing in the particular locality.

LETTERS[†]

Concerning A. B. 257—Impaired Hearing Statute:

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, June 5, 1943.

The Hon. Earl Warren,
Governor of California,
The Capitol,
Sacramento, California.

My dear Governor Warren:

Your attention is called to A. B. 257, which provides for an appropriation of $26,500 to the California State Department of Public Health, to be utilized in seeking out children in the lower school grades who are suffering from impaired hearing.

The Council of the California Medical Association has approved this measure.

We believe that many, many times the sum involved in the appropriation will come back to California, through increased efficiency, when these children assume their duties as citizens.

In addition, the humanitarian and public welfare phases, through promotion of happier and broader lives, must not be forgotten.

We hope you will deem it to be to the best interests of our people to attach your signature to A. B. 257.

Respectfully submitted,

FOR THE COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION.
Philip K. Gilman, M. D., *Chairman.*

(Editor's Note: A. B. 257 was approved by Governor Warren.)

[†] Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

[†] CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Concerning Recalcitrant Tuberculous Patients—Legal Opinion:

City and County of San Francisco
Department of Public Health

Dear Doctor Kress:

For your information, I am enclosing a copy of an opinion of City Attorney John J. O'Toole, regarding quarantine or enforced isolation of the recalcitrant tuberculous.

Sincerely,
(Signed) J. C. Geiger, M. D.,
Director.

* * *

Opinion of City Attorney

May 6, 1943.

Subject: In Re: Quarantine or Enforced Isolation of the Recalcitrant Tuberculous.

Dear Sir:

I have your letter under date of April 29 reading as follows:

"The following is taken from the California State Department of Public Health Report to Governor's Council:

" '*Enforced Isolation of the Recalcitrant Tuberculous.*

" 'On March 20, fifty superintendents of tuberculosis sanatoria, district attorneys, social workers and health officers attended a conference on the enforced isolation of the recalcitrant tuberculous in the Los Angeles office of the California State Department of Public Health. Many difficulties related to the problem were clarified during the five hours of discussion, particularly the power of the local health officer and his key position in the enforcement of isolation of the recalcitrant infectious tuberculous. While the officials in attendance upon the conference represented a wide diversity of interests, there was general agreement that action must be taken to prevent the continued contact of recalcitrant infectious tuberculosis cases with individuals who may not be immune to this disease.'

"Please advise what action we may take in cases of this type."

Opinion

The matters mentioned in the Governor's report are covered by the provisions of Articles 1, 2, 3 and 4 of the Health and Safety Code. Your attention is respectfully directed to the following sections:

"*Sec. 2571. Diseases to be reported. Protective measures.*

"The following shall be properly reported in writing to the State department by the health officer:

"Chickenpox, erysipelas, pneumonia, epilepsy, uncinariasis or hookworm, epidemic cerebrospinal meningitis, trachoma, whooping cough, mumps, dengue, dysentery, tuberculosis, typhoid fever, tetanus, malaria, leprosy, measles, German measles, glanders and anthrax affecting human beings, rabies, pellagra, beriberi, syphilis, gonococcus infection, poliomyelitis, and any other disease which appears to have become epidemic.

"This list of reportable diseases may be changed at any time by the State department.

"The diseases enumerated in this section, and such others as from time to time may be added by the State department, shall be quarantined whenever in the opinion of the State department that action is necessary for the protection of the public health, and shall be isolated whenever in the opinion of the department or health officer, isolation is necessary for the protection of the public health. (Enacted 1939; amended by later act passed at the same session, Stats. 1939, Ch. 375.)"

"*Sec. 2600. Noncompliance with department rules, etc.*

"Any person who, after notice, violates, or who, upon the demand of any health officer, refuses or neglects to conform to, any rules, order, or regulation prescribed by the State department respecting a quarantine or disinfection of persons, animals, things, or places, is guilty of a misdemeanor. (Enacted, 1939.)"

"*Sec. 2601. Exposure of self or another to communicable disease.*

"Except in the case of the removal of an afflicted person in a manner the least dangerous to the public health, any person afflicted with any contagious, infectious, or communicable disease who wilfully exposes himself; and any person who wilfully exposes another person afflicted with such disease in any public place or thoroughfare is guilty of a misdemeanor. (Enacted 1939.)"

"*Sec. 2602. Other violations: Separate offenses.* Any person who violates any section in Article 3 of this chapter, with the exception of 2555, is guilty of a misdemeanor, punishable by a fine of not less than twenty-five nor more than five hundred dollars, or by imprisonment for a term of not more than ninety days, or by both. He is guilty of a separate offense for each day that the violation continues. (Enacted 1939)."

You will note that Section 2571 provides that the communicable diseases mentioned in the section must be reported to the State Department of Health by the health officer. The last provision of the section provides that these diseases shall be quarantined "whenever in the opinion of the State department that action is necessary for the protection of public health."

Section 2601 makes the violation of the provisions of that section a misdemeanor. Therefore, it appears to me that, if there are persons within your jurisdiction who are suffering from recalcitrant tuberculosis in an infectious stage, such cases should be reported to the State Department of Health, and if the last mentioned department believes they should be isolated or quarantined, the department may authorize you to make the quarantine, and the breaking of the quarantine may be punished as a misdemeanor on application to the District Attorney.

Very truly yours,
(Signed) Jno. J. O'Toole,
City Attorney.

(Ed. Note: On this subject, see articles in the Tuberculosis Supplement of this issue.)

Concerning Aid Rendered by the California Medical Association in Support of Conservation of Hearing Laws:

(copy)

California Committee for Hard-of-Hearing Children
Santa Monica, California,
June 12, 1943.

Dear Doctor Kress:

I desire to express my sincere appreciation to you and to all of your officers and members who so kindly supported A. B. 257 and A. B. 1222, which the Governor signed.

I believe the medical profession in California can make a real contribution in the proposed conservation of hearing program. The otologists will take the lead, as it lies within their special field, but I realize fully that all the physicians who deal with children come into the picture. So do the scientists who are attacking the so-called "common colds," prolific generator of respiratory infections which often start hearing troubles. . . .

The next time I am in San Francisco I shall make it a point to see you. . . .

1303 Georgina Avenue.

Sincerely yours,
Conrad G. Selvig,
Secretary-Treasurer.

Concerning a Letter of Appreciation for Services Gratuitously Rendered by a Physician:

(copy)

U. S. Navy Recruiting Station
Federal Office Building, Civic Center
San Francisco, California
15 May, 1943.

Lloyd Bryan, M. D.
A. Justin Williams, M. D.
450 Sutter Street
San Francisco, California.

Gentlemen:

We find that during the past year you have made, without charge to us, in the neighborhood of one thousand x-ray films.

The major portion of these films have been chest pictures requiring large-sized films, so we fully appreciate the time and expense you have been put to in doing this work.

We hope that this letter will, in some small measure, express our appreciation and gratitude to you for this fine contribution toward the war effort.

In naval parlance, you have proved to be shipmates of the highest order, so the officers and crew of this station join me in wishing you and yours a happy and prosperous cruise.

(Signed) T. T. King,
Lieut. Comdr. D-V(S), USNR.,
Officer in Charge.

Concerning American Board of Otolaryngology: Midwinter E. E. N. T. Course in Los Angeles:

Los Angeles, June 29, 1943.

To the Editor:—The American Board of Otolaryngology will conduct an examination in Los Angeles on February 2 to 5, 1944, following the meeting of the Midwinter Clinical Course of the Research Study Club, provided at least fifty applicants are accepted. It is urgently requested that applications be submitted immediately so that the Board may plan accordingly. Address all applications to Dean M. Lierle, M. D., Secretary-Treasurer, University Hospital, Iowa City, Iowa.

The Thirteenth Annual Midwinter Postgraduate Clinical Course of the Research Study Club of Los Angeles will be given from January 17 to 28, inclusive, 1944, to be succeeded by the special course in Applied Anatomy and Cadaver Surgery of the Head and Neck, to follow immediately after the Clinical Course. Both courses afford an unusual opportunity for members applying to the American Board of Otolaryngology to obtain an up-to-the-minute refresher course just prior to their examination. . . .

1147 Roosevelt Building,

Yours very sincerely,
(Signed) Harold F. Whalman, M. D.

Concerning a Letter of Appreciation to the California Medical Association:

(copy)

The Stanford University Libraries
Stanford University
California

June 19, 1943.

Dear Mr. Hunton:

In acknowledging your letter of June 18 and the check for $1,125, representing the 1943 contribution of the California Medical Association to our Lane Medical Library, I want to tell the Association how much this assistance means to us at a time when we are under pressure not only to provide our usual service, but to assist the medical officers of our Army and Navy who are making active use of our facilities.

We will make every effort to continue to merit your support.

Cordially yours,
(Signed) Nathan van Patten,
Director.

Concerning California Medical Association Donations to California Libraries:

Library of the
Los Angeles County Medical Association
Los Angeles, California,
June 23, 1943.

To the California Medical Association Council:

We wish to acknowledge and thank the Council for the check of the California Medical Association in the sum of $1,125 as the 1943 contribution of the Association to the Library.

We have recently had numerous requests from medical men outside the County, but within the State, as well as from some in service outside the State. It has been a source of great interest and gratification to serve these men, and the check received each year from the California Medical Association helps make this service possible.

Again thanking you for your generous contribution,

Sincerely,
(Signed) Hazel M. Granger,
Librarian.

C.M.A. Medical-Nursing Liaison Committee

California Medical Association

May 28, 1943.

Association of California Hospitals
1182 Market Street
San Francisco, California
Attention: Mr. Kenneth Williamson, Executive Secretary

Dear Mr. Williamson:

Yesterday I read to you a letter addressed to Captain Philip K. Gilman, Chairman of the C.M.A. Council, and received from Councilor R. Stanley Kneeshaw, Medico-Dental Building, San Jose.

The letter referred to the problem of short-handedness in nursing personnel which has arisen at the San Jose Hospital.

You informed me that your Association had appointed a liaison committee to work with the State Nursing groups, and that this newly appointed committee would probably hold a meeting some time during the coming week.

Council Chairman Gilman has also appointed a special committee to represent the Council of the California Medical Association, the committee to consist of the following:

R. Stanley Kneeshaw, M. D., Medico-Dental Bldg., San Jose, Chairman.

L. A. Alesen, M. D., 1925 Wilshire Boulevard, Los Angeles.

Edwin L. Bruck, M. D., 384 Post St., San Francisco.

It is possible that when your own committee meets, it may wish to communicate with Dr. Kneeshaw to learn whether some member of his committee may also sit in at the conference.

We shall be happy to be kept informed of any new developments which may be pertinent to medical practice.

Cordially yours,
George H. Kress, M. D.,
Secretary-Editor.

MEDICAL EPONYM

Skodaic Tympany

This is described by Dr. Joseph Skoda (1805-1881), chief physician of the Vienna General Hospital, in his book, *Abhandlung über Perkussion und Auskultation* [*Treatise on Percussion and Auscultation*] (Vienna, 1839). A portion of the translation from the third edition (Vienna, 1844), follows:

"It would seem contrary to the laws of physics that a lung containing a small amount of air should give a tympanitic note, whereas the same lung with an increased air content is not tympanitic. The fact, however, is well established and is borne out not only by experiments made on the cadaver, which will be referred to later, but by the constant finding that in the presence of exudate in the thoracic cavity, which entirely compresses the lower part of the lung and markedly reduces the volume of the upper lobe, the percussion note is distinctly tympanitic over the upper part of the thorax."—R. W. B., in *New England Journal of Medicine.*

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 7, July, 1918

EXCERPTS FROM EDITORIAL NOTES

This Means Business—Read It!—There was described in a recent issue of the JOURNAL [Year 1918] the formation of the Volunteer Medical Service Corps. This Corps is designed to furnish an emergency medical organization, auxiliary to the medical establishments of the Army and Navy, for such military and civic duty as is not otherwise provided for. Members are to be those physicians who would be accepted for the Medical Reserve Corps, were it not for physical disability, over military age (55), essential public need, essential institutional need, or dependents. Women physicians are eligible. Members must be licensed graduates in medicine, and must apply for membership on regular blanks, which will be furnished by county secretaries or from the JOURNAL office. . . .

We have urged every doctor to make the need for Army and Navy medical officers a first claim on their attention. That the State of California is well represented by the enrollment thus far is shown by the following table:

County	Registers about	Number in service	Percentage
Alameda	528	51	9.6
Contra Costa	47	9	19.0
Los Angeles	1549	220	14.2
Orange	86	6	6.9
Sacramento	165	14	8.5
San Diego	74	38	51.3
San Joaquin	100	7	7.0
Santa Barbara	60	8	13.3
Santa Clara	170	19	11.1

Not the absolute figures, but the percentages are of special interest here. How is your county represented? If it is not equal to the percentage allotment for the entire State, which means an average of 20 per cent for each county, are *you* to blame? Why should not your county have its just and equitable proportion of medical officers? Why should not every county go beyond its quota? If your county percentage is below the allotment, why are *you* not enrolled in the Medical Reserve Corps?

But suppose you are not in uniform and are not commissioned in either the Army or the Navy Reserves, and you *have* a legitimate reason. And you are able and willing to do what you can in your own location, even though circumstances make it impossible for you to accept the call to active duty. *Then apply at once for enrollment in the Volunteer Medical Service Corps.*

Legal Aspects of Social Insurance.—An interesting meeting of the San Francisco County Medical Society was held June 11, 1918. The President, Dr. J. H. Graves, presided and in a few words introduced the subject of the evening, "Social Health Insurance," in which he recounted the appointment of the Social Insurance Commission of California to investigate the problem, its activities since its appointment by the Governor, and the general scope of its investigations.

Mr. Hartley F. Peart, General Attorney for the State Medical Society, then delivered a brief address on "Legal Aspects of Health Insurance." . . .

(Continued in Front Advertising Section, Page 14)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.
Secretary-Treasurer

Board Proceedings

"Results of examinations given candidates for licenses for physicians and surgeons and chiropodists were announced in Sacramento yesterday by Dr. Frederick N. Scatena, secretary-treasurer of the State Medical Board . . . 198 successful physician and surgeon candidates . . . took the tests in Los Angeles recently. . . ." (San Francisco *Examiner*, May 17, 1943.)

News

"Retirement of Dr. Seeley G. Mudd from the deanship of the school of medicine of the University of Southern California was announced yesterday by President Rufus B. von KleinSmid, together with the appointment of Doctor Mudd to the professorship of experimental medicine. He will be succeeded by Dr. Burrell O. Raulston professor of medicine and associate dean of the Southern California school." Los Angeles *Examiner*, May 16, 1943.)

"Of interest to his large circle of friends was the announcement made that last Thursday evening, Dr. R. R. Root was among a group of physicians who received traditional gold-headed canes in recognition of their long service in the Riverside County Medical Association. . . ." (Riverside *Enterprise*, May 20, 1943.)

"A total of 726 persons in April used the 'round the clock' telephone service of the San Francisco County Medical Society to obtain the services of a physician in an emergency, it was announced today. This was an increase of nearly two hundred over March, and indicates an increasing influx of newcomers to the city, the Society believes. . . ." San Francisco *News*, May 7, 1943.)

"Dr. Minnie L. Maffett of Dallas, Texas, president of The National Federation of Business and Professional Women's Clubs, Inc., recently prepared a statement asking for military rank and status for women doctors in the armed forces. The statement was presented at a public hearing of the subcommittee of the House Military Affairs committee in Washington recently. . . ." (Orange *News*, May 4, 1943).

"Small cards may some day be the means of saving the lives of at least some of San Francisco's 4,500 diabetics, in case of an air raid, it was announced today by Henry Gibbons, III, M. D., Chief, Emergency Medical Service. The identification cards, 2½ x 3½ inches, with a code number, indicate diets and amounts for the patient along with other personal data. The card will also give the insulin record for the person. This has been done so that in case of injury the diabetic's condition will be known at a glance to attending physicians who can then prescribe proper medicine and diets. The cards are obtainable from doctors and clinics." (San Francisco *News*, May 10, 1943.)

(Continued in Back Advertising Section, Page 28)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.

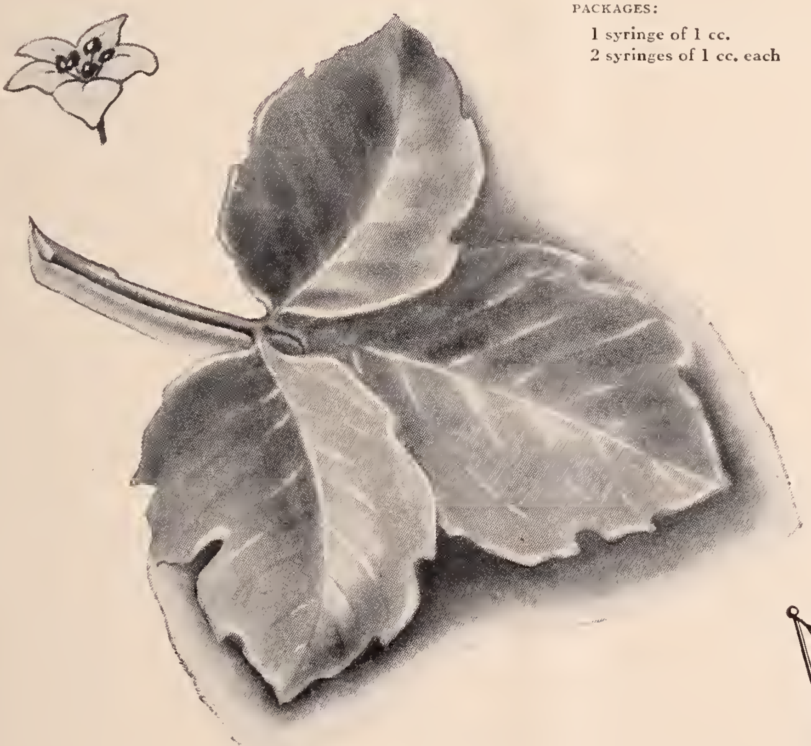
Prepare for the perennial risk of Rhus Dermatitis with

POISON OAK EXTRACT
Lederle

THE LOGICAL TIME for poison oak immunization is in the late Spring. By timely action an immunity may be secured which will alleviate future discomfort from casual or prolonged contact with poison oak. "Poison Oak Extract *Lederle*" is useful not only for the prevention of rhus dermatitis, but also for its treatment.

Protect susceptible patients early!

PACKAGES:
1 syringe of 1 cc.
2 syringes of 1 cc. each



Specify **Lederle**

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Los Angeles: 643 S. Olive Street
Lederle Laboratories Depot: 714 S. W. 12th Ave., Portland, Oregon
[A UNIT OF AMERICAN CYANAMID COMPANY]

STILL THE SAME OLD JOHNNIE WALKER

BORN 1820 . . .
still going strong

Unchanging quality has made Johnnie Walker a well-known character all over America.

Due to British war restrictions, gold foil has been eliminated and other slight changes have been made on the *outside* of the familiar Johnnie Walker bottle—but *inside* good old Johnnie Walker whisky remains unchanged.

Both 86.8 proof

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

CANADA DRY GINGER ALE, INC.
New York, N. Y. • *Sole Importer*

Bequest Forms:
Unto the Physicians' Benevolence Fund of the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $——— for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $———, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be paid to and become a part of the Physicians' Benevolence Fund of the California Medical Association as said fund is established and maintained by said Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I hereby give and bequeath unto the Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be expended by said corporation for the benefit and as a part of the Physicians' Benevolence Fund of the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California, for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association the following described real property situate in the county of ——— State of California, and more particularly described as follows, to-wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be held as a part of the Physicians' Benevolence Fund of the California Medical Association, the income whereof shall be used for the purposes of said fund as it is established and maintained by the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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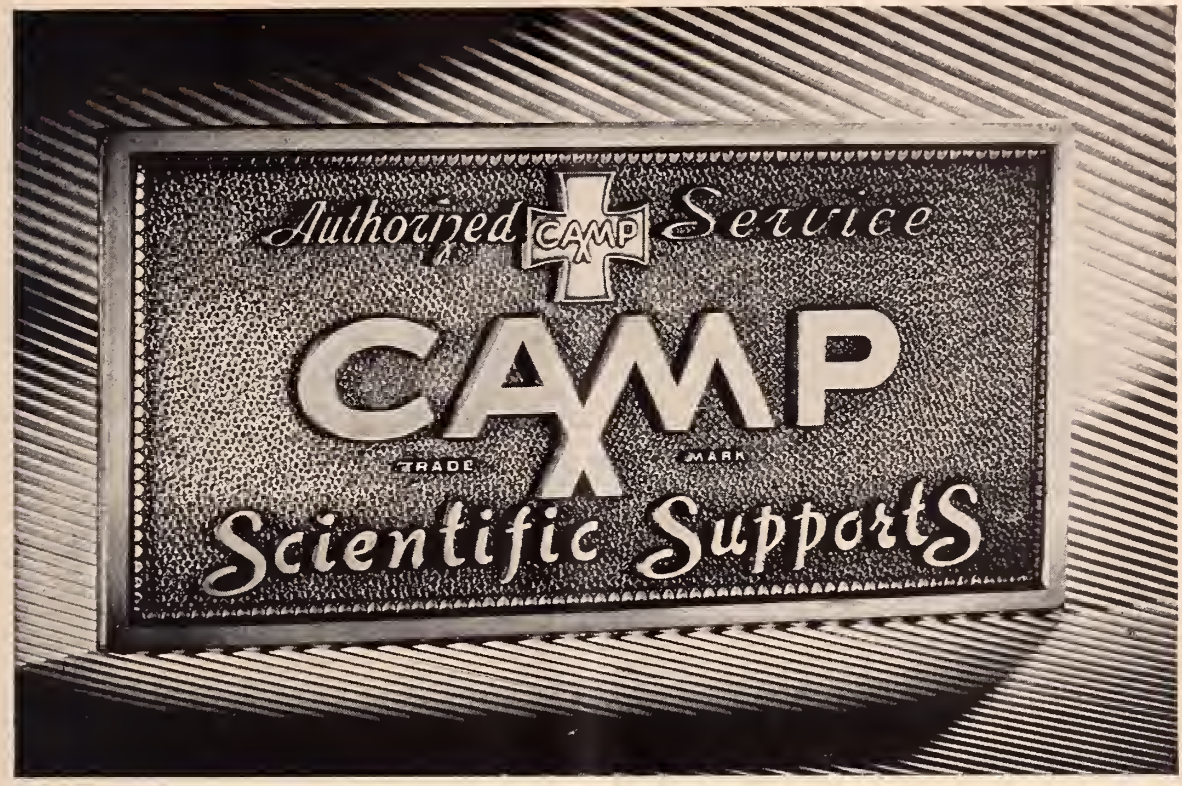
* Correspondence for the Physicians' Benevolence Committee may be addressed to the C. M. A. office or to Axcel E. Anderson, Chairman, 1759 Fulton Street, Fresno.



A Sign of Strength . . .

to endure through changing times

Consider the situation: Millions of women engaged in the heavier work of industrial jobs. Domestic help growing scarce so that even housewives work harder, longer. More maternity patients than in any time during the last two decades.

Result: More and more physicians are recommending Camp Scientific Supports according to the needs of the particular condition.

Easy to see why the symbol of Camp service is today more important than ever.

It assures doctors that every prescription for a Camp support will be filled exactly as ordered . . . by an expert, specially trained by the Camp organization.

It means that patients will find the prescribed garment available for immediate use, and at moderate prices.

Today, this responsible Camp service is a bulwark for physicians. For in an increasingly unstable field, it is filling a growing need unfailingly.

CAMP TRADE MARK *Supports*

S. H. CAMP & CO., JACKSON, MICH.
World's largest manufacturers of surgical supports.
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ORTHOPEDIC
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PENDULOUS ABDOMEN
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French Hospital

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Fifth Avenue
SAN FRANCISCO,
CALIFORNIA

A general hospital of 225 beds operating an accredited School of Nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and operated by the French Mutual Benevolent Society through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons.

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CHARLES J. MALINOWSKI . . . . *Superintendent*
H. M. GILFILLAN, M. D. . *Chief of Staff*
JAY JACOBS, M.D. . *Chairman of Staff*
MARIUS A. FRANCOZ, M. D. . . . . *Secretary of Staff*

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 22)

who is out for a good time. They cannot understand the boys can sky-lark and go to battle all the same day. . . .

With very good wishes, I am,

Yours truly,
R. H. Hunt.

Excerpts from an Article on "Head Measurements of Soldiers and Identification," by Arthur MacDonald, Anthropologist, Washington, D. C.—I have submitted to the War Department for consideration some of the reasons why the measurements of the maximum lengths and maximum widths of the heads of soldiers should be taken. I suggest that this be done when the height of the soldier is measured in his regular examination for military service. These measurements, with the collateral evidence—such as comparison of teeth with the dentist's record at home and with the evidence as to age, as indicated by ossification of the skeleton—will greatly increase the facility and probability of identification. . . .

Change in Casec Measurements.—Casec now measures six *packed* level tablespoonfuls instead of 12 level tablespoonfuls, as formerly, so that directions to the patient should be amended accordingly. Casec is indicated in colic and loose stools in breast-fed infants, and in fermentative diarrhea, malnutrition, celiac disease and for premature infants. Mead Johnson & Company, Evansville, Indiana, U. S. A.

There is nothing of which men are so fond, and withal so careless, as life.

—La Bruyère, *Les Caractères.* Sec. 10.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 104)

"Napa's awaited test case, expected to show how far a first aid director can go without infringing in the field of medicine, has been settled—without settling the issue. Don Imboden, first aid director of the Basalt Rock Company Shipyards, was acquitted yesterday by a directed verdict of a jury of a charge of practicing medicine without a valid license. The charge was based on a complaint of Joseph W. Williams, special agent for the state board of medical examiners. Williams contended Imboden 'went beyond the point' of giving first aid and in reality entered the field of medicine by giving repeated treatments. . . . The directed verdict came with a startling suddenness after only two witnesses, the subject of the treatments and a Napa physician, testified. Mary Jane Clarys, 19, shipyard timekeeper, testified Imboden treated a blister on the little toe of her left foot on two occasions with the result she went to a hospital for three days with a blood infection. Dr. Joseph Sooy testified he treated the girl in the hospital for an infection in the great toe of her right foot. District Attorney Wallace Everett, Jr., announced the disparity of testimony of his principal witnesses made it impossible to proceed and suggested 'the whole thing be dropped.' Justice of the Peace David N. Wright directed the jury to return a not guilty verdict and the acquittal was given from the box." (Sacramento *Bee*, June 3, 1943.)

"Accused of assisting in an alleged forced illegal operation upon Mrs. Virginia Crandall, last December 10, her husband John W. Crandall, and her mother-in-law, Mrs. Hazel Crandall, 13006 Aranbe Street, Willowbrook, are scheduled to receive a jury trial involving the state's medi-

(Continued on Page 30)

Peggy Bacon

MEN ARE NOT CREATED EQUAL

. . . At least, not equal with respect to *Rhus* sensitivity. About half of all contacts are susceptible to the irritant oleoresins of *Rhus toxicodendron* (poison ivy) and *Rhus diversiloba* (poison oak). However, tolerance appears to vary, and anyone *may* fall victim to the itching discomfort of *Rhus* dermatitis.

Oak and ivy poisoning are major nuisances connected with outdoor activities during the warm months of the year. Fortunately, *Rhus* dermatitis may be relieved or prevented in a majority of cases by injections of 'Ivyol' extract* developed by the Mulford Biological Laboratories of Sharp & Dohme, Philadelphia. 'Ivyol' extract contains the purified, vesicant principle (1:1000) of poison ivy. The vehicle is sterile olive oil and injections are therefore relatively painless . . . Supplied in packages containing one or four vials, each vial representing a single dose.

Prophylaxis: *Contents of one vial, administered intramuscularly each week for four weeks.*

Treatment: *Contents of one vial administered every 24 hours intramuscularly, until symptoms are relieved.*

*Nebraska State Med. J., 26:129, 1941

'IVYOL' POISON IVY EXTRACT MULFORD

For the prophylaxis and treatment of Poison Ivy and Poison Oak dermatitis

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A General Hospital With Accommodations for Three Hundred Patients
And Operating **THE MEDICAL OFFICE BUILDINGS,** *Facing the Hospital*
Tenancy Restricted to the Medical and Dental Professions

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Superintendent, V. W. OLNEY

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ALUM ROCK SANATORIUM

FOR DISEASES OF THE CHEST

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Telephone
MAYFAIR 321

A small select sanatorium for the treatment of Tuberculosis and other chest diseases.

Each patient receives individual study and care. The referring physician receives regular clinical reports.

Climate is ideal. Located at 1,000 ft. elevation, 6 miles east of San Jose, overlooking the Santa Clara Valley. A folder will be sent on request.

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Philip H. Pierson, M.D., San Francisco
Glenroy N. Pierce, M.D., San Francisco
Ina Gourley, M.D., Oakland

BOARD OF MEDICAL EXAMINERS

(Continued from Page 28)

cal practice laws. . . . Scene of the crime, it is alleged, was the home of Alma Baier, 700 West Artesia Avenue, south of Compton. Miss Baier, accused of actually performing the operation while the victim was held by her husband and mother-in-law, pleaded guilty to the same charge before Judge Kaufman and was permitted to file an application for probation which will be heard in court June 3 at 10 a. m. Bail of $500 was meanwhile posted. Bail on the two Crandalls was also set at $500 each pending their jury trial. . . ." (Compton *Herald-American,* May 13, 1943.)

"Arrest of a 65-year-old Cloverdale woman Friday ended what a state agent termed as a 'tuberculosis cure racket' that had operated in the northern county community for several years. Taken before Judge E. E. Gibbons of Cloverdale on a charge of practicing medicine without a license, Mrs. Beatrice Carr, known to friends as 'Dr.' Carr, pleaded guilty and was given a six months' suspended jail sentence. She was placed on probation for a year, with the understanding that she would refrain from giving any medical treatments. . . ." (Petaluma *Argus-Courier,* April 24, 1941.)

Minutes of the Meeting of the Review Committee of the Board of Medical Examiners

(Continued from June issue)

NAME	SCHOOL
Foster, Charles Gordon *San Fernando*	Coll. of Med. Evang., '43
Freidin, Morris *Los Angeles*	U. of So. California Sch. of Med., '43
French, William Forrest *Los Angeles*	U. of So. Calif. Sch. of Med., '43
Friedlander, Saul *Los Angeles*	U. of California Med. Sch., '43
Friedman, Seymour Warren *Los Angeles*	U. of Ill. Coll. of Med., '42
Gardner, William Charles *Los Angeles*	Coll. of Med. Evang., '43
George, Lowell Edwin *Los Angeles*	U. of So. Calif. Sch. of Med., '43
Gillespie, James Delos, Jr. *Los Angeles*	U. of So. California Sch. of Med., '43
Goutiere, Vernon Guillaume deM. *San Francisco*	U. of California Med. Sch., '43
Graham, William Howard *San Francisco*	U. of California Med. Sch., '43
Gray, Charles Wallace *Orange*	State U. of Iowa Coll. of Med., '42
Gregory, Dewey Quinton *Los Angeles*	Coll. of Med. Evang., '43
Gundelfinger, Benjamin Fremont *San Francisco*	U. of California Med. Sch., '43
Gunderson, Harley James *Los Angeles*	U. of California Med. Sch., '43
Gunn, Gordon Andrew *Los Angeles*	U. of Neb. Coll. of Med., '35
Haig, Pierre Vahe *Los Angeles*	U. of So. California Sch. of Med., '43
Healey (Templeton) Mildred *Los Angeles*	U. of Buffalo Sch. of Med., N. Y., '41
Heidepriem, Glen *Los Angeles*	Creighton U. School of Med., '42
Henderson, Charles Edwin *Los Angeles*	U. of Southern California Sch. of Med., '43
Henderson, Joseph Lewis *San Francisco*	Royal Coll. of Surg., Eng. Royal Coll. of Phys., Lon., '38
Hennessy, Thomas Gerard *San Francisco*	U. of California Med. Sch., '43
Hetman, Mitchell Joseph *Los Angeles*	U. of Ill. Coll. of Med., '42
Hicks, Rustan Howard *Escondido*	Coll. of Med. Evang., '43

(Continued on Page 32)

QUALITY—HIGH!

LIKE opticians everywhere, our members are experiencing a wartime manpower turnover of abnormal speed. Good lens grinders are needed in war industries; experienced all-around optical men are wanted by all the services. Our members have, however, met the situation squarely with intensive personnel training for new employees. You may rely on Association opticians for quality work.

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Roosevelt Building, Los Angeles

SUPERIOR OPTICAL CO.,
Roosevelt Building, Los Angeles

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324 Granger Building, San Diego

CHILDREN AND THE PHYSICIAN

Before the child is born and at birth, the physician plays an important part in safeguarding the health and well-being of both mother and babe. After birth, the physician's duty does not end. He must be prepared to recommend tested and effective methods for controlling and spacing the family. For 19 years, Servex Products have met this need and thousands of physicians prescribe them for proper child-spacing.

SERVEX INC.

LOS ANGELES, CALIFORNIA

May We Suggest CALSO WATER for the Urologists

Indications	Formula
For all genito-urinary infections, particularly the irritated bladder of Prostatics	Calcium Carbonate Magnesium Carbonate Sodium Chloride Sodium Phosphate Sodium Bicarbonate
Pre- and Postoperative Treatment	
Fluid Depletion	
Indicated in combinations with Sulfa therapy	

Sparkling Palatable Not a Laxative

●

THE CALSO COMPANY
524 Gough St., San Francisco, Calif.

CALSO WATER is not a laxative.

BOARD OF MEDICAL EXAMINERS

(Continued from Page 30)

NAME	SCHOOL
Higgins, Laurie Willard *San Diego*	U. of Mich. Med. Sch., '42
Hill, Wilmot Theodore *Orange*	Coll. of Med. Evang., '43
Ho, Wayne Yuan-hai *Los Angeles*	St. Johns U. Sch. of Med., China, '29
Holder, Richard McGhee *Pasadena*	U. of Louisville Sch. of Med., Ky., '42
Hollister, John Frazier *San Francisco*	U. of California Med. Sch., '43
Holmes, Robert Ogden *San Francisco*	U. of California Med. Sch., '43
Horning, Merritt Charles *Sacramento*	Coll. of Med. Evang., '43
Horton, Hammond Spalding *Los Angeles*	U. of Louisville Sch. of Med., Ky., '42
Howard, Frances Nan *Los Angeles*	U. of Ill. Coll. of Med., '42
Huntsman, Joseph Rupert *Los Angeles*	Johns Hopkins Sch. of Med., '42
Jacobs, Herbert Newton *San Francisco*	U. of California Med. Sch., '43
Jones, Paul Leishman *Oakland*	La. State U. Sch. of Med., '42
Kalick, Peter *Los Angeles*	U. of California Med. Sch., '43
Kaller, Robert Gerald *Los Angeles*	Marquette U. Sch. of Med., Wisc., '42
Kapstein, John Alan *San Francisco*	U. of California Med. Sch., '43
Karmy, Shukry Dibsy *Los Angeles*	Coll. of Med. Evang., '43
Kreutzer, Elwood William *San Diego*	U. of Oregon Med. Sch., '42
Kroopf, Stanford Shea *Carlisle Barracks, Pa.*	Harvard Med. Sch., '41
LaBriola, Joseph Harold *Los Angeles*	U. of So. California Sch. of Med., '43

(Continued on Page 36)

Periodical
Inspection
and
Adjustment
Service
"The Wisest
X-Ray Investment
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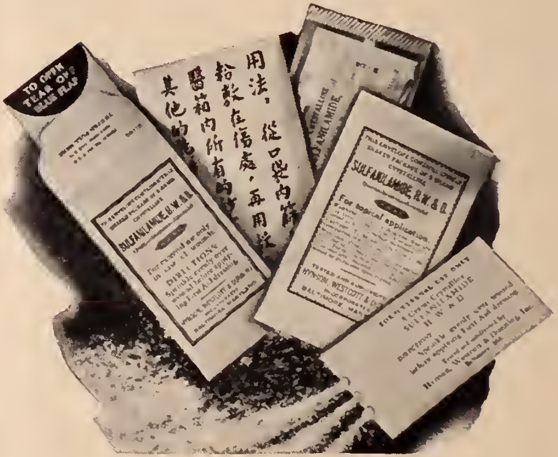

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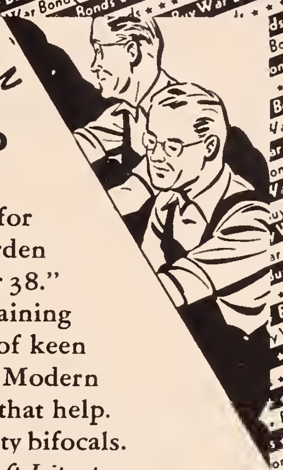

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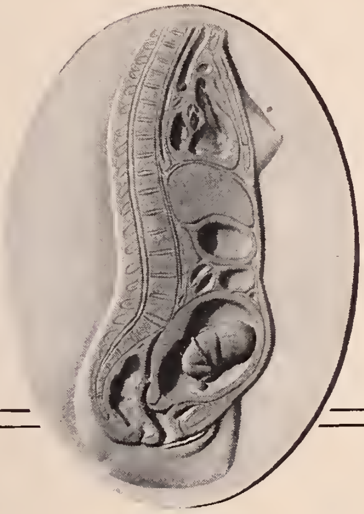

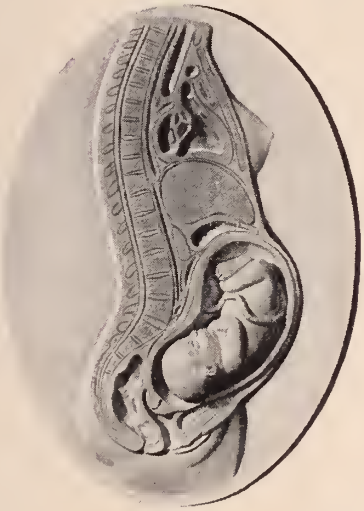

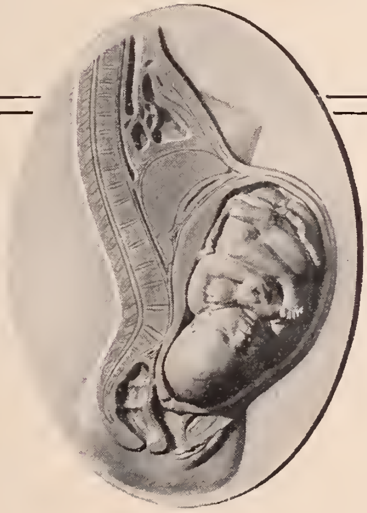

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Eighth District — Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties, Frank A. MacDonald (1945), 822 Medico-Dental Building, 1127 Eleventh Street, Sacramento.

Ninth District—Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma and Trinity Counties, John W. Green (1946), Box 539, Vallejo.

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Sam J. McClendon (1945), 2654 Fourth Avenue, San Diego.

Edwin L. Bruck (1945), 384 Post Street, San Francisco.

Captain Philip K. Gilman (1944), 703 Market Street, San Francisco.

E. Earl Moody (1944), 829 South Alvarado Street, Los Angeles.

Dewey R. Powell (1946), Room 501, 242 North Sutter Street, Stockton.

Edward B. Dewey (1946), Professional Building, 65 North Madison Avenue, Pasadena.

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(Continued on Page 5)

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(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland

President, Clifford W. Mack, Livermore Sanitarium, Livermore.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
President, Charles E. Plumb, 310 Main Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Secretary, J. M. Boomer, American Trust Building, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, William G. Milholland, 711 Bank of America Building, Fresno.
Secretary, Jerome A. Thormann, Power Company Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Charles C. Falk, Sr., 507 F Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, T. E. Bartholomew, 319 Third Street, Calexico.
Secretary, Henry Forcher, 319 Third Street, Calexico.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, William I. Shultz, 408 N. Main Street, Bishop.
Secretary, J. Lloyd Mason, 135 East Line Street, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. M. Nicholson, Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, G. R. Fortson,* Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles

President, E. Vincent Askey, 2210 W. Third Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles*

Marin County Medical Society
President, Rodney B. Hartman, 38 Bigelow, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, John H. Lloyd, Fort Bragg.
Secretary, Louise E. Petty, Talmage.
Meeting, *On Call.*

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Rollin Reeves, 32 E. San Luis Street, Salinas.
Secretary, S. Condit Glasgow, 8 E. Alisal Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth,* Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, D. A. Harwood,* 2145 Walnut, Santa Ana.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Edward S. Babcock, 1127 Eleventh Street, Sacramento.
Secretary, Carl E. Burkland, 510 Medico-Dental Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.*
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
President, W. Don Rolph, 640 National Avenue, National City.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Sidney J. Shipman, 490 Post Street, San Francisco.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Curtis M. Galt, 134 N. Lincoln Avenue, Manteca.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. F. Ragsdale, 717 Twelfth Street, Paso Robles.
Secretary, Harrison Eilers, Box 360, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, William A. Key, 23 Second Avenue, San Mateo.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, J. Irving Beattie,* 652 E. Santa Clara Street, San Jose.
Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
President, F. P. Shenk, Medico-Dental Building, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President*

Shasta County Medical Society
President, Oscar Jess Hansen, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Clifford M. Carlson, 576 B Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, 107 Crescent Road, San Anselmo.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, Frank L. Doane, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, G. C. Coffey, Bank of America Building, Ventura.
Secretary, M. M. Raines, 34 North Ash Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Ray E. Nichols, Woodland.
Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, John W. Lindstrum, 423 Fourth Street, Marysville.
Secretary, Joseph J. Salopek, 423 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

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(Continued from Page 3)

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California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco. Phone WEst 8000.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles. Phone Fitzroy 7694.

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Los Angeles — State Office Building, 217 West First Street, MAdison 1281.

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California Northern District Medical Society

President, John H. White, Chico.
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Board of Medical Examiners of the State of California

San Francisco—Room 214, 515 Van Ness Avenue.

Los Angeles—906 State Building.

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Secretary, Frederick N. Scatena, M. D., 1127 Eleventh Street, Sacramento.

Southern California Medical Association

President, Ray B. McCarty, 3116 Main Street, Riverside.

Secretary, Nelson Paul Anderson, 2007 Wilshire Boulevard, Los Angeles.

The Public Health League of California

Executive Secretary, Ben H. Read, San Francisco office, 251 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 5711.

Medical Schools of California

University of California Medical School, Third and Parnassus, San Francisco. Francis S. Smyth, M. D., Dean.
Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean.
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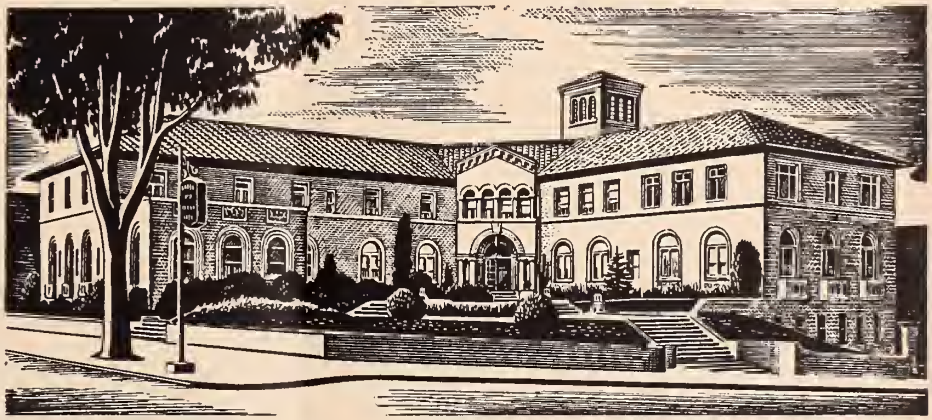

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New and Nonofficial Remedies, 1943. Containing Descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1943. Issued under the Direction and Supervision of the Council on Pharmacy and Chemistry of the American Medical Association. Cloth. Pp. 772. Chicago: American Medical Association, 1943.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1942. With the comments that have appeared in the Journal. Cloth. Chicago: American Medical Association, 1943.

A Synopsis of Clinical Syphilis. By James Kirby Howles, B. S., M. D., M. M. S., Professor of Dermatology and Syphilology, and Director of the Department, Louisiana State University School of Medicine; Senior Visiting Physician, Charity Hospital of Louisiana at New Orleans; Visiting Physician, French Hospital, Mercy Hospital, Hotel Dieu, Southern Baptist Hospital and Touro Infirmary. Cloth. Pp. 671, with 121 text illustrations and 2 color plates. St. Louis: The C. V. Mosby Company, 1943.

A Family of Thirty Million. The Story of the Metropolitan Life Insurance Company. By Louis I. Dublin, Ph. D., Third Vice-President and Statistician. Cloth. Pp. 496. New York: Metropolitan Life Insurance Company, 1943.

The Genealogy of Gynaecology. History of the Development of Gynaecology Throughout the Ages, 2000 B. C.-1800 A. D. With excerpts from the many authors who have contributed to the various phases of the subject. By James V. Ricci, A. B., M. D., Associate Clinical Professor

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of Gynaecology and Obstetrics, New York Medical College; Director of Gynaecology of the City Hospital, New York; Associate Attending Gynaecologist and Obstetrician, Flower and Fifth Avenue Hospitals, New York; Consultant in Gynaecology and Obstetrics, Broad Street Hospital; Fellow of the New York Academy of Medicine. Department of Gynaecology and Obstetrics of the City Hospital, New York. Cloth. Price, $8.50. Pp. 578, with illustrations. Philadelphia: The Blakiston Company, 1943.

Methods of Treatment. By Logan Clendening, M. D., Clinical Professor of Medicine, Medical Department of the University of Kansas; Attending Physician, University of Kansas Hospitals; and Edward H. Hashinger, A. B., M. D., Clinical Professor of Medicine, Medical Department of the University of Kansas; Attending Physician, University of Kansas Hospitals; Attending Physician, St. Luke's Hospital, Kansas City, Mo. With Chapters on Special Subjects by J. B. Cowherd, M. D.; Leland F. Glaser, M. D.; Thomas B. Hall, M. D.; John S. Knight, M. D.; H. P. Kuhn, M. D.; Paul H. Lorhan, M. D.; F. C. Neff, M. D.; Don Carlos Peete, M. D.; Carl O. Rickter, M. D.; E. H. Skinner, M. D.; O. R. Withers, M. D.; and Lawrence E. Wood, M. D. Eighth edition. Cloth. Price, $10. Pp. 1,033. St. Louis: The C. V. Mosby Company, 1943.

BOOK REVIEWS

Medical Malpractice. By Louis J. Regan, M. D., LL. B., Member State Bar of California. Cloth. Pp. 256. St. Louis: The C. V. Mosby Company, 1943.

"Medical Malpractice," by Louis J. Regan, M.D., LL.B., fills a vacancy in legal texts and is an important accession to the library of lawyers engaged in active practice in this field. While it deals with the subject in an authoritative

(Continued on Page 14)

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New reprints available on cigarette research—Archives of Otolaryngology, February, 1943, pp. 169-173—March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York 17, N. Y.

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manner from the legal standpoint—the text being supported by numerous citations from the reports—it is at the same time a readily understandable handbook, the study of which will be beneficial to every practicing physician.

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We were particularly interested in the chapters entitled "Malpractice Vulnerability" and "Malpractice Prophylaxis," and we are in thorough accord with the short chapter entitled "Conclusion" which, because of its brevity and importance, we quote as follows:

"There must be recognition of malpractice as a problem; that the conditions created by it are harmful to the physician and injurious to the public; and that action must be taken to counteract it. The public should be informed as to (1) what constitutes malpractice and (2) how really few cases of actual malpractice occur. There should be better understanding, too, of the physician's duties, his capacities and limitations, of what may reasonably be expected of him.

"Physicians must learn what they may do to safeguard themselves, and must put into effect every possible precaution against an unjust malpractice accusation.

"The average medical man does not need to be urged to follow the dictates of good practice, but it seems that he does have to be urged to take precautions to protect himself against malpractice claims. To be in a position to do so effectively requires a little study, but this should not be regarded as burdensome, since it will enable him to keep his practice out of the courts."

Skin Grafting of Burns: Primary Care—Treatment—Repair. By James Barrett Brown, M. D., Lieutenant Colonel, Medical Corps, Army of the United States; Senior Consultant in Plastic and Maxillo-facial Injuries and Burns, E. T. O., U. S. A., Associate Professor of Surgery, Washington University, St. Louis, Missouri; and Frank McDowell, M. D., Assistant in Clinical Surgery, Washington University, St. Louis, Missouri. Cloth. Price, $5. Pp. 204, with 131 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

This work is a brief yet comprehensive one which recognizes the importance of treating the patient from the instant he is burned until he is rehabilitated in so far as his condition allows, although the authors emphasize skin grafting primarily. The importance of general care, including shock, is emphasized and modern treatments now being used here and in England are reported in detail. Local care is discussed, with attention being focused on the trend away from "closed or sealing-in methods" to the "open surgical drainage" methods now being used so effectively. The author has incorrectly classified paraffin wax as a "sealing-in method," whereas it has been successfully demonstrated that paraffin wax has the peculiar property of preventing burn secretions from crusting over and "sealing in" the toxic substances. This is particularly true when used as the modified open air spray technique. This method uses only a thin coat of paraffin wax formula with no other dressings, thus permitting perspiration and excess secretions outside the wax film to be washed away frequently by water showers. The wax incorporates contaminating materials and in this way does its own cleaning. Blebs are not ruptured.

(Continued on Page 16)

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BOOK REVIEWS

(Continued from Page 14)

The use of plasma is presented and the worth of other generally recognized treatments evaluated. One author, who has recently been in England, reports the methods now being used there. The rôle of pressure dressings is brought out and the fact reported that their use is limited to the United States. Their use in preparing areas for skin grafting is commended. Many unusual techniques are presented, including the Bunyan bags and their ever-popular "Tulle grass" used with gauze.

The book then emphasizes the need for early skin grafting of full thickness burns. The use of free, partial thickness skin grafts has been found most efficacious for general use. All different types of skin grafting and plastic repair are described, and detailed instructions, the carrying out of which are so essential for their successful use, are given. Probably not enough attention is given to the prevention of contractions and disuse atrophies which can frequently be prevented by early motion. One novel feature is the presentation in detail of the technique of the type of skin graft best adapted to each part of the body.

The varieties of skin grafts are discussed, giving the advantages of each and methods of preparing them. Detailed instructions are given for preoperative and postoperative care in each area and type of graft. Some space is devoted to pedical flaps and general types of plastic repair in different types of scars, skin shortening, and contractures, too commonly found after severe burns. Many chapters deal with the different anatomical regions of the body, indicating the common complications found in each, the proper procedure in each case and the reason for it,

(Continued on Page 17)

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BOOK REVIEWS

(Continued from Page 16)

and, finally, the pitfalls that should be avoided to insure success.

The authors have drawn on a wealth of clinical experience as well as reporting experiences of others. Very little waste of space is given to historical or discontinued procedures except as they affect the modern conception of burn care, including skin grafting. The entire book is adequately illustrated and well organized. The care of the patient as well as the burn, right up to his return to duty, presents a point of view so essential to prevent delayed healing and prolonged disabilities.

Diseases of the Liver, Gallbladder and Bile Ducts. By S. S. Lichtman, M. D., F. A. C. P. Adjunct Physician, Mount Sinai Hospital, Assistant in Post-Graduate Medical Instruction, University Extension, Columbia University, New York. Cloth. Price, $11. Pp. 906, with 122 engravings and a colored plate. Philadelphia: Lea & Febiger, 1942.

This book presents the existing knowledge of the liver and its diseases. The usual sequence is followed: anatomy, physiology, symptomatology, and so on. The index is good, and one can find specific information quickly. Material of academic interest and detailed laboratory technique is set apart in fine print.

The chapters on pathogenesis and pathology of jaundice, and on liver function tests are clear and helpful.

The sentence structure is better than average for contemporary medical writing. Occasional constructions are confusing.

This book can be recommended to the general practitioner and surgeon as a convenient and complete work of reference. For the internist it is a scholarly review of the literature up to 1942.

K. W. BENSON, M. D.

Human Pathology. By Howard T. Karsner, M. D., Professor of Pathology, Western Reserve University, Cleveland, Ohio. Cloth. Price, $10. Pp. 817, with 460 illustrations in black and white and 24 subjects in color on 16 plates. Sixth edition, completely revised and reset. Philadelphia: J. B. Lippincott Company, 1942.

The sixth edition of Doctor Karsner's well known textbook of Pathology appears in an entirely new guise. The book is longer and wider, but thinner, making it easier to handle. The format is completely changed and the new pages have two columns of short lines which should facilitate reading and study. Many new sections have been added and old ones rewritten. Many of the older drawings have been replaced by excellent photomicrographs and photographs. In this extensive revision, Doctor Karsner has maintained the same high standards set in earlier editions. As usual, the compact sentences are built on a beautifully organized framework. The references are kept up to date and only the more useful older ones retained. It is a book not only valuable for the student in medical school, but for the use of the general practitioner who wishes to keep fresh in his mind the fundamental underlying causes of the symptoms he is called upon to treat.

M. R. OLDT.

Therapeutics of Infancy and Childhood. Edited by Harry R. Litchfield, M. D., F. A. C. P., Lecturer in Pediatrics, Postgraduate Medical Education, Kings County Medical Society-Long Island College of Medicine; Attending Pediatrician, Beth-El Hospital, Brooklyn Women's Hospital, Brooklyn Thoracic Hospital; Chief of Pediatrics, Watkins Street Dispensary, Brooklyn, New York, and Leon H. Dembo, M. D., Visiting Pediatrician, St. Luke's and St.

(Continued on Page 18)

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BOOK REVIEWS

(Continued from Page 17)

Ann's Hospitals, Cleveland, Ohio. Containing 117 contributions in four volumes, with a desk index. Profusely illustrated. Philadelphia: F. A. Davis Company, 1942.

This four-volume work, complete with index, is unique in the realm of pediatric textbooks. Although clinical diagnosis and pathology are discussed, therapy in particular is emphasized. The whole field of both medical and surgical conditions of childhood is thoroughly dealt with. Well printed, excellently bound, and with numerous fine illustrations, these books have incorporated all the newest therapeutic agents employed in pediatric practice.

If any fault can be found with this excellent work, it is that the therapy of certain diseases—for example, the allergic group, should be more thoroughly described instead of referring the reader to other texts. Perhaps in later editions some of the discussions of clinical diagnosis will be omitted and replaced by a complete therapeutic description.

Furthermore, such a treatise as the "Therapeutics of Infancy and Childhood" should perhaps be loose-leafed to allow for the rapid changes in the general field of therapeutics. Despite these minor shortcomings, this new text can be highly recommended to both general practitioner and pediatrician.

S. H.

Roentgen Treatment of Diseases of the Nervous System. By Cornelius G. Dyke, M. D., F. A. C. R., Associate Professor of Radiology, College of Physicians and Surgeons, Columbia University; Director, Department of Radiology, Neurological Institute of New York, and Leo M. Davidoff, M. D., F. A. C. S., Chief, Department of Surgery, Attending Neurological Surgeon, Jewish Hospital of Brooklyn.

(Continued on Page 20)

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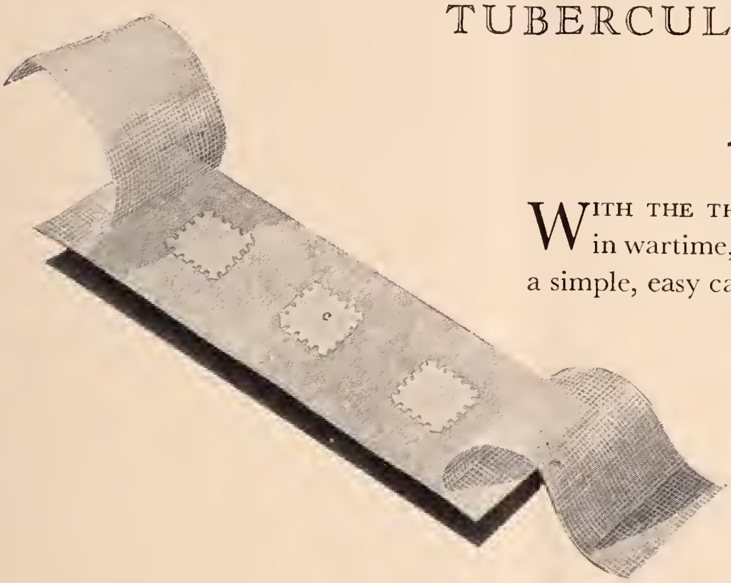

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BOOK REVIEWS

(Continued from Page 18)

Cloth. Price, $3.25. Pp. 198, with 12 engravings, 7 charts and 16 graphs. Philadelphia: Lea & Febiger, 1942.

Dyke and Davidoff have compiled a tremendous amount of data which they have reduced to a concise report of their experience in treating neoplastic diseases of the cerebrospinal axis with roentgen therapy. This book contains not only the pathologic indications of x-ray treatment, but also the exact technical details for the administration of the therapy. Many specific cases are outlined and the end results recorded.

As far as possible, the authors have included the general methods used by other leading roentgenologists in the application of x-ray therapy to diseases of the nervous system. Many other interesting features have been added, including an excellent review of the history of x-ray therapy and a résumé of the important experimental and laboratory investigations of roentgen therapy.

Lester B. Lawrence.

Tuberculosis as It Comes and Goes. By Edward W. Hayes, B. S., M. D., F. A. C. P., Associate Professor of Tuberculosis, College of Medical Evangelists, Los Angeles; Member of the attending staff Los Angeles General Hospital, Division of Tuberculosis; Physician in charge of the Tuberculosis Clinic and Sanatorium of the Orange County Hospital, Orange, California; Director of Tuberculosis, Imperial County, California; Medical Director and Physician in charge of the Maryknoll Sisters Sanatorium and the Keane Sanatorium, Monrovia, California. Cloth. Pp. 187, illustrated. Livingston, Columbia County, New York, U. S. A.: The Livingston Press, 1943.

This little book by one of the leading medical practitioners of tuberculosis has been designed primarily for the patient and other laymen. As such, it serves a very useful purpose and comes at an opportune time since most small books written for this purpose are now somewhat out of date. The size of the book makes it convenient for the tuberculous patient. Its content comprises almost all of the things that a tuberculous patient should know.

A brief but comprehensive history of tuberculosis introduces the subject, followed by the common facts of infection with the tubercle bacillus and how it may be controlled. Doctor Hayes wisely emphasizes the distinction between tuberculous infection and tuberculous disease. He has introduced a series of drawings illustrating disease processes in the lungs which are certainly illuminating for a medical man. It will be interesting to see how useful they prove to be to the tuberculous patient. I should imagine that the average patient would find them extremely interesting. The various forms of treatment are adequately dealt with, including the modern concepts of collapse therapy.

All in all, the book is to be highly recommended for the purpose for which it was designed. If a few minor errors

(Continued on Page 22)

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BOOK REVIEWS

(Continued from Page 20)

have crept in, such as speaking of lymph glands rather than lymph nodes, and the like, these are only to be expected in the first edition of such a work and they can be corrected in future editions of the same volume.

Sidney J. Shipman.

Chemotherapy of Gonococcic Infections. By Russell D. Herrold, B. S., M. D., Associate Professor of Surgery (Urology) College of Medicine, University of Illinois, Chicago, Illinois. Cloth. Pp. 137. St. Louis: The C. V. Mosby Company, 1943.

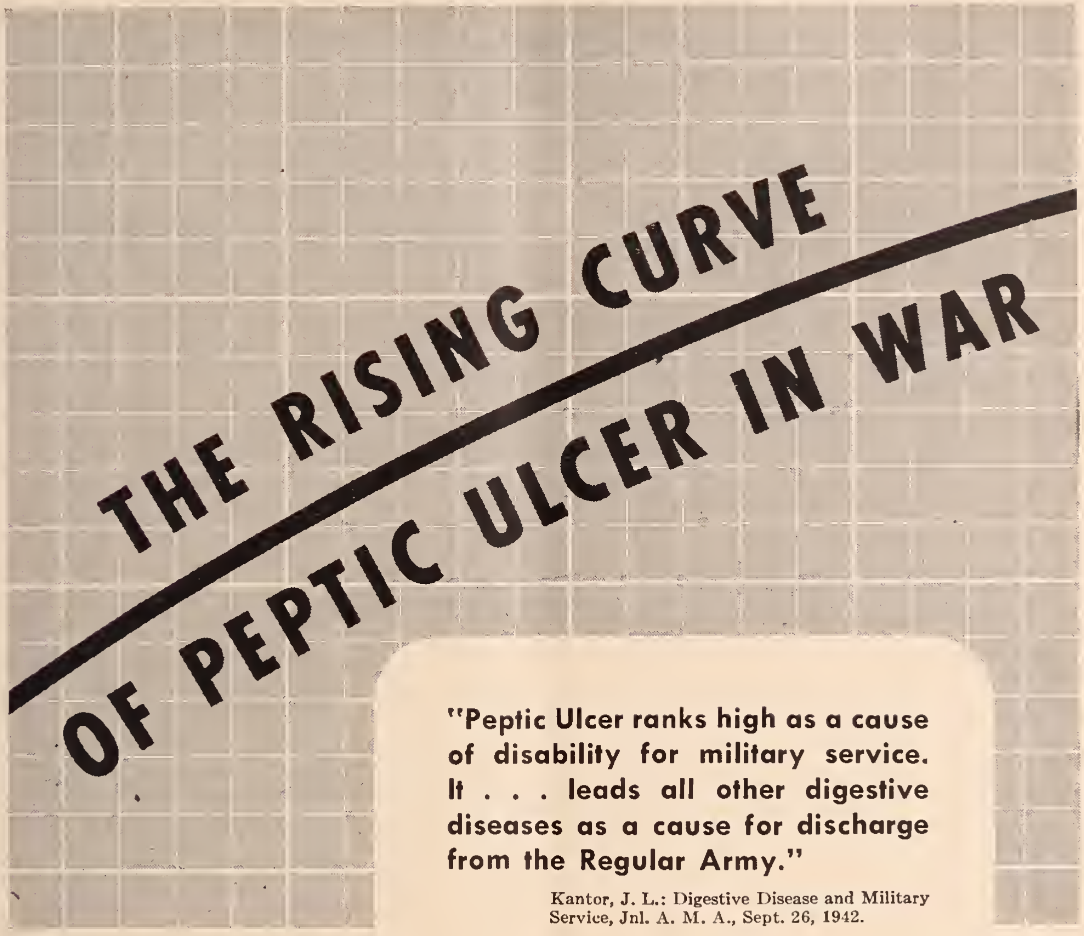
In this monograph the author announces his intention to present a streamlined conception of chemo-therapeutic treatment of gonorrhea. The most critical reviewer could hardly claim that he has not fulfilled his promise.

Absent are chapters on bacteriology, pathology and historical references of discarded methods. One notes with relief that the customary chapters on diet have been omitted.

There are discussions of the different sulfa preparations. Sulfathiazole is the drug of preference, though he seems to leave a door open for sulfadiazine if it should improve on acquaintance.

There is an important chapter on management of sulphonamide failures which should be read with attention. It appears to be the concentrated extract of a long experience. Drug reactions are considered at length. The symptoms are presented and the importance of frequent appraisals of the

(Continued on Page 24)



THE RISING CURVE OF PEPTIC ULCER IN WAR

"Peptic Ulcer ranks high as a cause of disability for military service. It . . . leads all other digestive diseases as a cause for discharge from the Regular Army."

Kantor, J. L.: Digestive Disease and Military Service, Jnl. A. M. A., Sept. 26, 1942.

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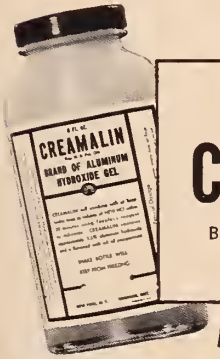

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BOOK REVIEWS

(Continued from Page 22)

patient, with discontinuance of the drug on appearance of toxic manifestations.

Dr. Herrold gives 4 grs. of sulfathiazole daily for three or four days and if continued beyond the fifth day, 2 grs. daily for five more days, followed by a rest.

The criteria of cure is completely presented with the recommendation of the use of cultures and observance for three months.

Complications are rather briefly mentioned, probably because, as he states, chemo-therapy has greatly decreased their incidence. For resistant cases he discusses local treatment and mentions the use of fever therapy.

There are two chapters on infections of women and children. Doctor Herrold confirms the generally accepted opinion that sulfa therapy is better borne by children than by adults. Estrogen treatment is mentioned and evaluated. The last part of the book contains 62 case histories in which other problems are presented.

This book should be within the reach of everyone who treats gonorrhea.

J. A. DOUGHERTY, M. D.

A Handbook of Medical Library Practice.—Including Annotated Bibliographical Guides to the Literature and History of the Medical and Allied Sciences. Based on a Preliminary Manuscript by M. Irene Jones. Compiled by a Committee of the Medical Library Association, Janet Doe, Editor. Cloth. Price $5.00. Pp. 609. Chicago: American Library Association, 1943.

After three years of coöperative effort, a special committee of the Medical Library Association witnessed, on June 1, the appearance of its *Handbook of Medical Library Practice.* Under a special arrangement with the Medical Library Association, the American Library Association has published this important new manual—a book which brings to medical librarians their first comprehensive treatise on practice and operations in their field.

This book is published as a nonprofit venture, and, because of its special nature, has been issued in a very small edition.

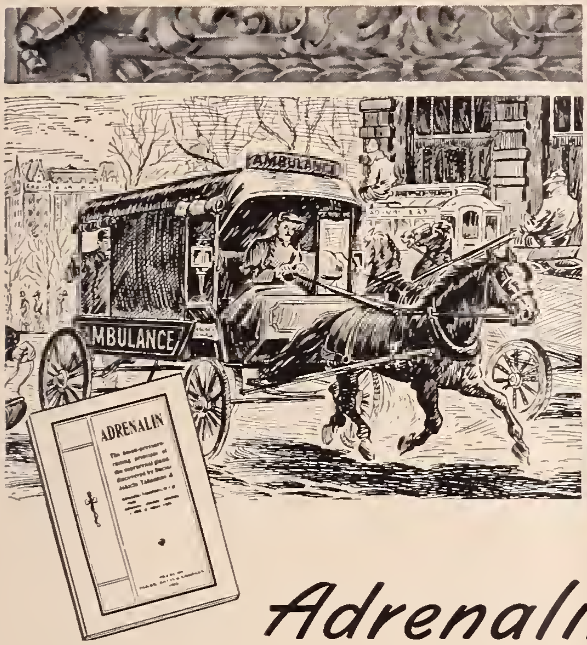
The book is both a manual of procedure and reservoir of useful data. "It is an attempt to imitate ontogeny by recapitulating in one volume the experience of the race of medical librarians," says the Introduction; it acquaints the general librarian with the special problems of the medical library. Accompanying the chapters on procedures are appendices which have brought together extensive bibliographies, lists, and guides.

In Chapter VIII, an *Annotated List of Reference Books* includes 625 items, carefully described, and provides the blueprint for building the foundation of any medical library that is to attempt reference service. This important guide covers 165 pages, and alone is a significant contribution to medical librarianship. There are also lists of medical libraries here and abroad; the principal expansions of medical classification schemes; a guide to bibliographies, bibliographic collections, and histories useful in historical medical collections.

The principal chapters cover medical library administration, selection and ordering of books and periodicals, cataloging, subject headings, classification, pamphlets, pictures, maps, microfilms, reference work, rare books, and the history of medicine.

In order to keep the price within the reach of all who might make use of the manual, the Medical Library Association has heavily subsidized its publication.

(Continued in Back Advertising Section, Page 28)



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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

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Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

OBSTETRIC AND PEDIATRIC CARE OF WIVES AND INFANTS OF ENLISTED MEN: FEDERAL CHILDREN'S BUREAU PLAN

Important Statement of Michigan State Medical Society.—A letter dated July 28, 1943, on "Subject: Proposed Program of Obstetric-Pediatric Care for Wives of Enlisted Men," was addressed "To Every Member of the Michigan State Medical Society." In its last sentence it gave expression to this important statement:

"In its present form the [Federal Children's Bureau] plan (with payment direct to physicians) is definitely socialized medicine."

With that opinion, many members of the California Medical Association are in accord.

* * *

References to Informative Data.—CALIFORNIA AND WESTERN MEDICINE, in June (on pages 313-317) and July (on pages 1 and 79-88) has striven to present some of the informative letters and other data that led the California Medical Association Council not only to adopt its resolution concerning the Children's Bureau plan (see Item VI, on page 81, in July CALIFORNIA AND WESTERN MEDICINE), but to send to component county medical societies and their members the letter containing information that could serve as a guide for them in procedures which they, as individual physicians, might desire to take.

At the time of this writing, no new developments have come to the front, and therefore the Council's resolution and letter stand.

* * *

Text of the Michigan State Society Letter.—Because the Michigan letter referred to above so well states certain facts, further quotations are here given:

THE COUNCIL OF THE MICHIGAN STATE MEDICAL SOCIETY

1. *Opposes and disapproves* the plan for maternal and pediatric care to wives and infants of enlisted men as long as payments are made direct to physicians.

2. *Will approve* a plan *when* payment is made direct to the wives of enlisted men.

* * *

The attention of every member of the Michigan State Society is invited to the fact that if he signs application blanks for the plan *as offered to date* and participates in the program, it will:

1. Encourage the development of a poor quality of obstetric-pediatric care—a condition which always follows the operation of a regimented program (governmental).

2. Establish a precedent for further extension of governmental intrusion into the private practice of medicine. (Next may come eye, ear, nose, throat; then another, and, finally, all the sections including medicine and general surgery.)

3. Commit to this type of governmental program those 1,842 members of the Michigan profession who are in military service, without giving them the opportunity to express their opinion.

4. Open the door to governmental medical service for *all,* without economic distinction or determination of need.

5. Establish a fee schedule, which tends always toward revision downward. . . .

* * *

Any member who participates in the present governmental plan is doing so against the advice and opinion of the Council of the Michigan State Medical Society, the House of Delegates of the American Medical Association, and the Michigan State Advisory Council of Health. These groups have decided against the program of the U. S. Children's Bureau only after detailed study and consideration. By your action now you determine the future of the private practice of medicine.

* * *

Strange Inaction of the American Medical Association.—The serious implications as regards medical practice involved in the Federal Children's Bureau plan—and so well stated in the above excerpts from the Michigan letter of July 28—make it most difficult to understand why the national mouthpiece of organized medicine, *The Journal of the American Medical Association*, has made no editorial comment thereon!

The question is being asked, "Why the silence on this important issue when, on numerous subjects of lesser import, many press association dispatches emanate from the American Medical Association office in Chicago to appear in the newspapers throughout the length and breadth of the United States?"

* * *

Items Which Have Appeared to Date in the "Journal of the American Medical Association."—The following items have been noted in recent issues of *The Journal of the American Medical Association:*

1. A brief statement of news-item nature in the Miscellaneous Department (*The Journal of the American Medical Association,* issue of July 17, 1943, on page 816).

2. A one-page article by Dr. Edwin F. Daily, Director of the Division of Health Services, Children's Bureau, U. S. Department of Labor, in which the procedures indicated in the Children's Bureau Circular No. 13 of March 29, 1943, are outlined. (See June CALIFORNIA AND WESTERN MEDICINE, on page 315, and *The Journal of the American Medical Association,* issue of July 31, on page 945).

When these two items are scanned, and the letter of the Michigan State Medical Society also read, one cannot do otherwise than ask the question, "How has it come about that the American Medical Association—with all its special facilities and presumable representatives who are in contact with the higher powers in Washington, D. C.—has failed to inform the constituent state associations and their members, who make up also the membership of the American Medical Association, concerning the importance and significance of the impending Federal Children's Bureau plan?"

* * *

American Medical Association Fee Schedules as Quoted by Representatives of the Federal Children's Bureau.—In California, the fact that Dr. Edwin Daily of the Federal Children's Bureau was permitted to contact state medical associations, and get as far west as California without seeming contradiction on his statement that the initial proposed fee schedule of $35 to cover prenatal, confinement and postpartum care was based on some three hundred fee tables secured from the American Medical Association, continues to be a source of wonderment when California physicians discuss the matter. (See also on page 133.)

When on March 19 last the Federal Children's Bureau circular was issued, should not that have been sufficient notice to the national organization to promptly institute contacts with the proper governmental authorities so that authoritative fee schedule information from the American Medical Association headquarters would have been made available to the Washington officials?

* * *

American Medical Association House of Delegates and Newly Created Council on Medical Service and Public Relations.—On June 7, at the meeting of the American Medical Association House of Delegates, held this year in Chicago, Dr. John H. Fitzgibbon of Portland submitted the resolution on the Federal Children's Bureau plan previously adopted by the Pacific States Medical Executives' Conference at Portland on May 30, 1943 (see CALIFORNIA AND WESTERN MEDICINE, June, page 317, and *The Journal of the American Medical Association,* June 19, page 547). The American Medical Association House of Delegates accepted the basic provisions of that resolution (*The Journal of the American Medical Association,* June 26, page 621, and CALIFORNIA AND WESTERN MEDICINE, July, Item VII, page 82.) However, when the newly created American Medical Association "Council on Medical Service and Public Relations" held its first or organization meeting on July 21, it did not take action on the Federal Children's Bureau plan for obstetric-pediatric care. That American Medical Association Council will meet again in September. In the meantime, many things may happen.

* * *

Is Not "Time of the Essence"?—Are not the issues here discussed of sufficient importance to warrant action by the American Medical Association that would be more than what might be called "marking time"? If the American Medical Association had given early attention with action to the proposition and had sent adequate information to the constituent state associations, it is quite probable that other state units would have gone on record along lines that have been indicated by the

Michigan, Oregon, Ohio, and California State Medical Associations.

Is it fair to a small group of constituent state medical associations to make them carry on this battle against governmental intrusion into the domain of private medical practice? On a subject of national scope, is it not to be expected that the national organization will point the way?

* * *

How California Medical Association Members May Aid: Letter of President Schaupp.—In the meantime, it may be in order to print here, as a reminder to California Medical Association members, the letter of August 3 that was sent to the component county societies and members of the California Medical Association by Dr. Karl L. Schaupp, California Medical Association president, who is also chairman of the committee appointed by the Council to represent it in matters related to the Federal Children's Bureau plan.

In that communication, President Schaupp requests California Medical Association members to contact or write the California Senators and the district Congressmen, and point out ways of federal procedure that would make for a better quality of obstetric and pediatric care. The objective in this is to promote the conservation of those practices in scientific medicine that have been shown to be more acceptable to the citizens of the United States. In the light of experience, those procedures will also better safeguard and promote the public health interests of our nation.

President Schaupp's letter follows:

(COPY)
California Medical Association
August 3, 1943.

The Component County Societies of the California Medical Association and Their Members,
Addressed

Dear Doctors:

The July issue of California and Western Medicine presents a fairly complete survey of the Federal Children's Bureau Plan of Obstetric and Pediatric Care for the Wives and Infants of Enlisted Men (see first editorial on page 1, and the eighteen explanatory items commencing on page 79).

This letter is sent to suggest that your Society may wish to appoint a committee to call this subject to the attention of your local Congressman (whose address is given under Item XVI on page 85), before he returns to Washington.

Individual members of your County Society may also wish to write him. You are his constituents. He should be glad to receive your opinions.

It should be possible to enact legislation whereby federal money could be paid direct to the wives, they to choose their own physicians. Concerning this, see comment on page 85 (Michigan suggestions at bottom of left-hand column) and page 88 (Ohio plan).

The list of members of the Special California Medical Association Committee on the Federal Plan appeared on page 315 of the June issue of California and Western Medicine.

Your aid in having your local Congressman acquire a better understanding of the issues at stake will be much appreciated.

Cordially yours,
Special California Medical Association Committee.
(Signed) Karl L. Schaupp, *Chairman.*
Donald G. Tollefson, *Vice-Chairman.*

COLLEAGUES IN MILITARY SERVICE: SOME OF THEIR PROBLEMS

Number of Available Physicians for Military and Civil Practice.—Many physicians who are in civilian practice have been so busy with extra work that they have had but little time for serious thought concerning the trials of colleagues who are in the armed services. Of the 180,000 doctors of medicine who are licensed in the United States it was estimated by the Federal Procurement and Assignment Service in December, 1942, that after some 42,000 physicians who are military officers had been deducted, a total of 94,500 effective physicians remained for civilian practice in the United States. About one-half of the physicians in military service are under 45 years in age. At the present time, for about every two physicians in civilian practice, there is one doctor of medicine in the armed forces. In the United States Army, the ratio of physicians to military personnel is about 1 to 150. The proportion in civilian practice varies from a prewar figure of one physician to about 1,022 persons, to a present wartime general average of 1 to 1,500; although in certain sparsely populated and also in some boom industrial areas, the ratio may run from one doctor of medicine to 3,000 persons or more—the 3,000 population ceiling being set as the dividing line where critical public health menaces may come into operation.

In the July issue of California and Western Medicine, on page 78, appeared a War Manpower Commission directive dated June 7, 1943, in which it was stated that all physicians up to 45 years of age who were not actually essential in civilian life would be called upon to apply for commissions as medical officers. Referring to this directive, *The Journal of the American Medical Association,* in its issue of August 7, 1943, placed a colored box on the front-cover index with the words:

"6,000 MORE PHYSICIANS NEEDED NOW!"

The text of the editorial in that number is played up in full-page size and black-face type on page 1016, in order to emphasize the importance of the appeal. Those who have not acquainted themselves with the content of the directive, should not fail to do so. In this current issue of California and Western Medicine, for excerpts therefrom, see page 124.

* * *

On Allocations and Responsibilities of Physicians in Military Service.—It is granted there is a considerable difference between the military ratio of one doctor of medicine to 150 military personnel, and the civilian figures of one physician to 1,500 persons, but that does not mean colleagues in military service do not have as great responsibilities. Certainly, in combat and certain foreign areas, surgeons attached to the Army, Navy, and Air Forces are being called on for services that far transcend anything experienced by colleagues who continue to carry on under peaceful home surroundings.

Which fact may be used to remind those of us who continue to care for the needs of civilians that military colleagues in spare moments—whether in stations in the United States or overseas makes little difference—may be doing some serious thinking concerning the todays and tomorrows of medical practice.

Conversations with and communications received from medical officers reveal some of the things talked about in camps by the members of the medical staffs. It may be in order to mention some of these items, since they can be provocative of thought that may guide future action by those of us who remain at home.

* * *

Sacrifices by Physicians in Military Service.—Nearly all physicians who volunteered for service in the Army or Navy, or who entered because they came within the statutory age limits, left established private practices, in the development of which they had given their best efforts through varying periods of years. Since in medical practice so much of every physician's success is dependent upon his own personal qualities, it follows that when a civil practice is left by him it cannot be maintained in the same building or offices, as is possible with industrial and trade businesses. It is evident, therefore, that on entrance into military service, the physician places himself in a position—when and if ever he returns to private practice—which in most cases will mean that he will be obliged to start all over again; and almost under the same conditions as those which faced him when he left his interneship to take up his initial civil practice. In the meantime, he has grown older and such a prospect is less enticing than in days of youth.

Further, the situation as portrayed is almost always complicated by the fact that, with these thoughts of his future he must keep in mind always his responsibilities to his wife and children and their economic and welfare needs.

* * *

On Return to Civil Practice.—Military colleagues are quite aware that they have signed up for the "emergency." Even though war with the Axis powers may come to an end, such a date does not mean automatic and prompt return to civil practice. So long as the Commander-in-Chief deems the emergency to exist, and for some six months thereafter, medical officers may be retained in service. This element of the intangible and unknown does not always make for mental comfort.

Also, depending upon his assignments while he is in military service, the physician may feel himself slipping farther and farther away from the routine experiences of private practice. This, too, may lead to doubt on whether he will be able to again build up an adequate practice in limited time, and without going into financial debt.

* * *

Refresher Courses on Coming Out of Service.—The difference between military practice for men and civil practice for men, women, and children needs no comment. Military colleagues cannot escape thinking about the contrasts, however, and only too often are tempted to wonder how well fitted they will be to renew routines of healing-art procedure that were discarded when they took up military life.

It would be reassuring to them if they could know that when they again come out of service to resume the performance of civil work that short, intensive refresher courses, devised to give them an over-all insight into changes that may have developed in civil practice, would be available.

Here, then, is some planning for postwar days that must be gotten under way at an early day. It is gratifying to know that the four California medical schools, and the special California Medical Association Committee are giving this subject careful attention (see Council minutes, Item 11(I), in July CALIFORNIA AND WESTERN MEDICINE, on page 76).

* * *

Hospital Appointments.—Civil hospitals must be adequately staffed, of course. However, it must be appreciated that a situation wherein alien physicians and physically disabled graduates are now taking places as residents, which would have been filled by younger men who are at the present time in military service—and who are thus being denied the opportunity to better prepare themselves for their life work in general medicine and the specialties—is not a consoling thought to these younger colleagues. The above is mentioned because many military colleagues feel that these facts should be kept in mind by hospital authorities, and that the necessities rather than the luxuries of residencies is what should be the goal of hospital maintenance. There should be no neglect to civilians, but, on the other hand, the obligations to military colleagues should not be forgotten.

* * *

American Medical Association Fellowship Standing.—The financial sacrifice made by a physician who enters military service needs no elaboration. It comprehends something more than the salary received by the medical officer. His station in civil life required the maintenance of certain standards, so that many officers find their salaries insufficient to cover the established home needs of their families. Hence, expenditures of money must be scrutinized in order that loved ones be not made to suffer.

Therefore, when a statement for eight dollars is received by a military colleague who has maintained American Medical Association Fellowship, it is not surprising that he is apt to wonder on the extent to which Organized Medicine appreciates his service to our country. In other words, in all the beautiful sentiments expressed, how much is real and how much, mere lip appreciation?

With the onset of war the California Medical Association met its obligation in this by transferring from its general funds the money necessary to cover the annual assessments, thus exempting these military members from the payment of dues and maintaining by this procedure their active membership in both the California and American Medical Associations.

It is to be hoped that, at the next session of the American Medical Association House of Delegates steps will be taken to bring about the adoption of a suitable by-law that will reëstablish and continue to maintain American Medical Association Fellowship for all American Medical Association members who were Fellows at the time of their entrance into military service. Constituent state associations have taken analogous action in regard to state association membership. Why should not the wealthy national organization bring similar procedures into being as regards American Medical Association Fellowship?

* * *

On Letters to Military Colleagues.—Several medical officers have called attention to letters from colleagues in civil practice who complain, and make such statements as "The large amount of extra income in civil practice hardly compensates for the heavy work and hours involved." The expression of such sentiments is not of a nature to receive kindly reception by the medical officers who have given up all in order to make possible the maintenance of civil practice and the freedoms we hold dear. In other words, a letter should not particularize overmuch the "hardships of colleagues in civil practice." That line of thought is better omitted in letters to friends in the Services.

* * *

On Salaries of Medical Officers.—One suggestion received had to do with salaries of medical officers. The point was made that the training and responsibilities of medical officers are such that, in order to be in fair proportion to what civilians in wartime work receive in the way of compensation—and also because of the uncertainty of promotion to higher rank with increase of pay, that the initial commission for all medical men who voluntarily enter military service should not be less than that of a captaincy in the Army. Whether any steps can be taken to bring about a betterment in this direction is not known. The subject should be worthy of study.

* * *

Ohio State Medical Society's Card.—At county society meetings and in staff rooms there has been much conversation on our obligations to our military colleagues. It is agreeed, both as regards professional and lay circles, there is well-defined recognition of the splendid services rendered to the armed forces by the medical profession. This is shown, for instance, by the excerpts from newspaper editorials which have appeared since July, 1942, in issues of CALIFORNIA AND WESTERN MEDICINE (in the Miscellany Department, under the caption "Doctors of Medicine as Others See Them." In this issue, see page 146.)

The Ohio State Medical Society has gone farther, however, and in its official journal recently inserted a full-page size and beautifully illuminated card for placement in the reception rooms of members who remain in civil practice. Its text is worthy of consideration, and is given here to conclude these comments:

> OUR OBLIGATION
>
> Perhaps the physician who has been providing you with medical services is one of the many Ohio physicians now on duty with the Army and Navy.
>
> While he is making this sacrifice for you and me, you may count on those of us who remain on the home front to do our utmost to meet your medical needs.
>
> However, it is my sincere hope that when your doctor returns, you will resume your former relationship with him.
>
> ...., M. D.

WAGNER-MURRAY-DINGELL SOCIAL SECURITY OR "CRADLE TO GRAVE" BILL (S. 1161; H. R. 2861): ITS PLACE IN RELATION TO MEDICAL PRACTICE

Some of the Background of S. 1161 and H. R. 2861.—Much has been written in recent weeks concerning the revised Social Security plan introduced as a Senate bill (S. 1161) on June 3 by Senators Robert F. Wagner (D., N. Y.) and James E. Murray (D., Mont.), and submitted as a companion House Resolution (H. R. 2861) on the same day by Congressman John D. Dingell (D., Mich.). An alias for this proposed "Cradle to the Grave" law is "the A. F. L.-C. I. O. bill," the measure seemingly having the sponsorship of the executive bodies of those labor organizations.

The bill is a follow-up or descendant of other measures introduced in recent years by Senator Wagner, but it also has close relationship to propositions put forth in an almost 500,000 word report by President Franklin Delano Roosevelt's "National Resources Planning Board," of which board his own uncle, Mr. Delano, is chairman. Mr. Arthur J. Altmeyer, chairman of the Federal Social Security Board, also has given the measure his blessing. Its provisions incorporate a considerable number of the activities included in what is known as the English Social Security Plan—a 100,000-word report—of which Sir William Beveridge, a recent lecture-visitor in the United States, is the special proponent.

So much in the way of information concerning the source material or inspiration personalities that have been identified with this "cradle to the grave" or "diaper to coffin" measure, as it has been called by some.

* * *

Medical and Hospitalization Care Are Among the New Features.—One of the reasons members of the medical profession should take special interest in the Wagner-Murray-Dingell bills is the inclusion of an elaborate set-up designed to provide in the not far distant future—through funds to be raised for the purpose—for federal insurance coverage for more than 100,000,000 of the population of the United States. It has been calculated that for hospital care alone, a sum between six and seven million dollars would be required. For additional information concerning the financial phases of the plan, the reader is referred to the article "Regimentation of Medicine," which appears in this issue on page 112.

It is even provided in S. 1161 that the medical schools of the United States could be taken over and be maintained by the Government. Thus, medical graduates in days to come would be governmentally subsidized and indoctrinated from the first day of entrance into the freshman class of a medical school! This is somewhat similar to certain educational systems that have led to much havoc and sorrow in portions of Europe.

* * *

The Great Pooh-Bah for All the Medical Work Would Be the Surgeon-General of the United States Public Health Service.—In this new plan to place under governmental supervision medical education and practice, and medical and hospitalization care of more than one hundred million of fellow citizens, little less than totalitarian powers would be vested in one man—he, in turn, a governmental appointee, namely, the Surgeon-General of the United States Public Health Service.

As the chief administrator and dispenser of the vast sums of money involved in an annual collection of $3,000,000,000 or more each year, there would be placed on the shoulders of this one individual responsibilities almost as great and as incomprehensible to most Americans, as are the billions of dollars concerning which there has been much comment in the press in recent years.

It is true that the Wagner-Murray-Dingell bill provides for a "National Advisory Medical and Hospital Council," to consist of sixteen members, but these are to be appointed by whom? By the Surgeon-General of the United States Public Health Service, who, as before stated, will have all the powers of a totalitarian Pooh-Bah! Is it not possible to conjure conditions under which these appointees, or a majority of them, would be little more than "yes men"?

* * *

Brochure of the "National Physicians' Committee for the Extension of Medical Care" and Statement No. 11 by the "Committee for the Improvement of Medical Care, Inc."—The National Physicians' Committee performed a notable service when it sent to physicians its illuminating brochure, "Abolishing Private Medical Practice or $3,048,000,000.00 of Political Medicine Yearly in the United States," in which a factual analysis of the Wagner-Murray-Dingell bill is given. Every doctor of medicine who has not received the brochure should send his request for a copy to the National Physicians' Committee, Pittsfield Building, Chicago, Illinois.

In contrast, it is of side interest to note that the "Committee of Physicians for the Improvement of Medical Care, Inc.," an organization founded some seven years ago and of which Channing Frothingham, M. D., of Boston, is chairman and John P. Peters, M. D., of New Haven, Connecticut, is secretary, has come out of its retirement to issue Statement No. 11 (its last previous statement appeared in 1941). This organization promptly wrote Senator Wagner "The Committee of Physicians for the Improvement of Medical Care wishes to congratulate you on the presentation of S. 1161 . . . ," etc. Then follows some discussion on medical education and medical man power, the statement closing with some doubtful comment concerning the National Physicians' Committee and the source of the latter's funds and policies.

The National Physicians' Committee brochure and Statement Number 11 are of interest, since the first is realistic in its approach, and the other—far less so.

* * *

English Panel System of Physicians Is Included.—A panel system of physicians akin to that in operation in England is provided in S. 1161. The physician has the right to indicate whether he wishes to participate. However, knowing that the payments for services will come from federal funds which in good part will be under the supervision of lay bureaucrats, it is not difficult to imagine what kind of "political medicine" would soon come into being to take the place of medical practice as it has been so successfully conducted to date under a system of free enterprise.

* * *

California Medical Association Members Must Inform Themselves Concerning the Wagner-Murray-Dingell Bill.—It is to be hoped that members of the California Medical Association will take the time to inform themselves as fully as possible concerning the Wagner-Murray-Dingell bill.

But this self-education will not be enough! What is much needed is that every Doctor of Medicine in California shall perform his duty as a citizen, and as a member of the medical profession, by informing the two United States Senators from California and the Congressman from his district that he believes that the "Wagner-Murray-Dingell bill (S. 1161, H. R. 2861)" contains provisions that will be detrimental to the best interests of the public health, and that its passage would work to the harm of their constituents.

Readers are requested to refer to page 85 of the July issue of CALIFORNIA AND WESTERN MEDICINE, on which appeared the names and addresses of the United States Senators and Congressmen from California. Certainly, a letter to three of our national legislators is a service that is not too much to ask of every physician who loves his profession and wishes to do his bit in maintaining its standards in the promotion of the public health.

Many physicians fail to appreciate that earnest lawmakers wish to be kept in touch with the views of their constituents. In two recent union meetings of county medical societies held in northern California, two legislators, State Senator Herbert W. Slater of Santa Rosa and State Assemblyman Ernest C. Crowley of Fairfield, emphasized this fact, and pointed out that, if it was hoped they and their fellow legislators were to vote intelligently on medical matters—since their knowledge was naturally limited concerning medical practice and public health matters—it would be necessary that their friends in the medical profession give them the essential informative data on these matters, to aid in their discussions and actions.

Wherefore, write your Federal Senators and your District Congressman. Why not do this now?

* * *

On How Members of the U. S. Congress May Be Kept Informed Concerning Public Health Legislation: California Public Health League.—No State in the Union has been confronted with adverse public health legislation more often than California. Only during the past several years has it begun to dawn on some of the eastern medical brethren how many and grave have been the public health problems (a term here used to comprehend licensure and other medical practice matters) that the medical profession of this State has been called upon to solve. That the solutions at times have been partial only and not entirely satisfactory should cause no wonderment. One need only look at kindred organizations in other commonwealths to be assured of this.

However, there is one accessory activity in which the medical profession of California may take pride, namely, the "California Public Health League."

This organization, composed of physicians, dentists, and nurses, is well organized in almost every county in the State. Its influence at Sacramento in protection of public health legislation cannot be gainsaid.

How has this been brought about? The answer is simple—by having key men and active workers in the legislative district of every State Senator and State Assemblyman who make it a point to keep these legislators in proper touch concerning the merits of proposed public health legislation. True it is, in order to maintain the efficiency of such a system, a strong central office and a representative are necessary.

In California there has been some hesitancy concerning extension of the work to include federal legislation. However, with impending social unrest and the many vagaries and theoretical expositions that are presented in the legislative chambers at Washington, D. C., and also in the absence of a coördinated effort under national auspices, California is not hesitant in presenting its plan to other constituent state medical associations as one worthy of most careful consideration.

It is all so evident. Members of the United States Congress will be glad to listen and act in proper manner when they know that a strong and influential group of constituent citizens is watching how their votes on public health matters are cast in the chambers of the Senate and House of Representatives.

In other words, to be heard in the legislative halls in Washington the opinion is spreading here, no matter what other States do or do not do, California henceforth must keep in better touch with its Federal Senators and Congressmen.

If, in every State in the Union there existed an actively working organization such as the California Public Health League—whether under such a name and as a separate entity, or a similar set-up as an expression of a Committee on Legislation and Public Policy of a constituent state medical association, would make little difference—then the deplorable and pathetic situations which have been coming to the front with increasing frequency at Washington, D. C., would probably not have arisen.

Let us keep in mind—

The message that will have most weight will be that which comes from the Senator's and Congressman's own constituents. There is no substitute for this.

EDITORIAL COMMENT†

POLIOCIDAL ACTION OF OZONE

Demonstration that certain strains of poliomyelitis virus are refractory to concentrations of chlorine used in routine water purification[1] has led Kassel[2] and his co-workers of the University of Southern California to study the possible poliocidal efficiency of ozone, which has long been known to be effective against certain other resistant microörganisms (*e. g.*, Endameba histolytica cysts). Two strains of poliomyelitis virus were diluted with saline solution and subjected to parallel sterilization tests with chlorine and ozone. In the chlorination tests, a tenth-volume of sodium hypochlorite solution or an equivalent amount of gaseous chlorine was added to the dilute virus, the final residual titer of the chlorine usually being about 0.5 p.p.m. In the ozonation tests, ozonized air was bubbled through the dilute virus mixture, the residual amounts of ozone usually being 0.05 p.p.m. At stated intervals measured samples of each mixture were treated with identical amounts of sodium thiosulphate and immediately injected intracerebrally into monkeys, the inoculation tests usually being made in triplicate. The resultant fatalities showed that the poliomyelitis virus is inactivated "almost immediately" (within two minutes) by ozone, while nearly three hours were usually required for similar inactivation with chlorine. Ozone, thus, is far superior to chlorine as a viricidal agent which "warrants additional experimentation."

W. H. Manwaring.

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† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

PERTUSSIS ANTITOXIN

Isolation of a strain of Hemophilus pertussis capable of forming a high-titer specific toxin in artificial culture medium is currently reported by Roberts[1] of the Lederle Laboratories, Pearl River, New York.

Since the discovery of H. pertussis, preparation of a soluble whooping cough ectotoxin has been attempted by numerous investigators. Bordet,[2] Toomey,[3] Wood[4] and others succeeded in obtaining toxic filtrates from certain strains of the bacillus, capable of killing mice on intra-abdominal or intravenous injection, and of producing necrotic lesions on endermic injection into rabbits. These filtrates, however, were apparently nonantigenic, since they were not neutralized by an antibacterial immune serum, nor did they stimulate the production of antitoxin in laboratory animals. For this reason they were of little practical interest.

In the hope of improving such yields, the Lederle bacteriologists tested 61 different strains of H. pertussis on numerous types of culture media. The medium finally selected was a buffered beef heart infusion broth containing 2 per cent peptone and 0.1 per cent soluble starch. The broth was adjusted to pH 7.8 before autoclaving. The broth was inoculated with 24-hour seed cultures of the 61 strains, the resultant growths centrifuged and the supernatant fluids sterilized by passage through a Mandel filter.

Most of their 61 pertussis strains yielded practically nontoxic filtrates. Massive doses (0.5 c.c.) injected intravenously failed to kill mice. A few of the filtrates, however, were moderately toxic, killing mice in doses as small as 0.25 c.c. Culture No. 33, in contrast, yielded a highly toxic filtrate giving a 100 per cent mouse fatality on intravenous injection of doses as small as 0.021 c.c. death taking place within 24 hours. Injected endermically in 0.1 c.c. doses in rabbits, this filtrate caused local necrosis, the lesion reaching its maximum size in from 2 to 3 days, and subsequently sloughing to form a shallow ulcer.

The lethal and necrotic factors in this filtrate are thermolabile at all temperatures from 2° to 60°. At ordinary refrigerator temperatures (3 to 5° C.), the toxicity decreases about one-half within a month, and is completely lost by the end of 12 months. At ordinary room temperatures the toxicity is lost within 30 days, at 40° C. within 24 hours, and at 50° C. within 10 minutes. The lethal and dermal necrotic titers are lost simultaneously. Deterioration of the toxin can be prevented by the addition of 50 per cent glycerin, or 50 per cent sucrose, or by evaporating it to dryness. Dried filtrates suffer no demonstrable loss of toxicity for at least 18 months.

Toxin No. 33 is first demonstrable in broth cultures in about 2 days, increasing to a maximum titer in from 6 to 10 days. The toxin is highly antigenic. Rabbits are readily immunized by repeated subcutaneous injections of the filtrate, after which their skin is refractory to both the toxin and to live cultures of all strains of H. pertussis thus far tested. Rabbits thus immunized yield an antitoxic serum readily titrated by *in vitro* methods. Nontoxic toxoid prepared by the addition of formaldehyde, also stimulates the production of a specific antitoxin in rabbits.

While Roberts does not predict probable clinical application of the new toxoid and antitoxin, it is evident that the discoveries will stimulate new hope of improved methods in specific therapy and prophylaxis. Th situation is analogous to that in diphtheria and tetanus toxins a generation ago. The discovery thus represents one of the most encouraging contributions to basic immunological science of recent decades.

P. O. Box 51.

W. H. Manwaring,
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Regimentation of Medicine*

Do you want the United States Government to take over and operate the practice of medicine? Do you want another bureaucrat, called a "Surgeon-General," to tell you whether or not you can be attended by the physician of your choice? Do you want to pay 6 per cent more of your wages into another governmental scheme for taking over another portion of your private life and create another gigantic bureau to regulate things here in this democracy of ours?

That's what Senators Robert F. Wagner (D., N. Y.) and James E. Murray (D., Mont.) propose in a bill introduced in the Senate to broaden the Social Security Act, and which will be called up for action when Congress reconvenes in September.

Under the guise of adding domestic and farm workers, sailors, employees of religious and charitable institutions, public servants and other smaller groups to the eligibles for old-age pension and unemployment insurance benefits, the bill would set up a detailed plan for bringing State Medicine to the United States, run from Washington by the United States Surgeon-General.

To finance the scheme, Social Security taxes on both employers and employees would be steeply increased. They would go to 6 per cent of wages up to $3,000 a year from each of these parties, as against the present 1 per cent from employees and 4 per cent from employers. Add that to your 20 per cent withholding tax and where are you?

One-fourth of the revenue raised would go to finance the Federal Government system—an estimated $3,000,000,000 a year. With this money the Surgeon-General would be required to arrange for general medical, special medical, laboratory, and hospital services for every one of the estimated 110,000,000 Americans covered by a broadened Social Security Act. He would be, as the New York *News* points out, the commissar of the United States medical profession, because of the powers this proposed law would give him.

These powers include: To enlist physicians for the services above described and hospitals likewise; to fix fees of physicians rendering such services; to limit the number of patients to be cared for by each physician; to prorate patients among available physicians; to finance medical education and medical research.

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* For editorial comment, see page 109-110.

Out of his $3,000,000,000 a year, the Surgeon-General is supposed to spend $60,000,000 for administration (more jobs for bureaucrats) and would pay out $2,400,000,000 in benefits. Under the "benefit" head he would be required to spend 2 per cent of the $2,400,000,000 or $48,000,000 on medical research and education. With this sum he could pretty thoroughly rip American medical education as follows:

Pay total cost of operating all sixty-six accredited United States medical colleges	$21,491,248
Subsidize 22,000 medical students at $700 a year for four years each	15,400,000
Spend for other research per year	11,108,752
	$48,000,000

Or if the medical schools and doctors objected to this, he could wreck them by spending his money this way:

Duplicate all existing medical teaching facilities in the U. S. A.	$22,000,000
Pay 20,000 additional medical students $700 a year apiece during their period of training	14,000,000
Spend in other ways as he pleased	12 000,000
	$48,000,000

The bill also empowers the Surgeon-General to muscle into the dental and nursing professions and "improve" them—something he would be well provided with taxpayers' money to do. What improvement any political control can bring to the medical, dental or nursing profession is another question, and we think, in view of the record made by most of our existing bureaus for regimentation, a most dubious one.

There are many weaknesses in our present system. Every individual should be entitled to all the benefits of modern medical science, if and when needed, regardless of his financial condition. Every child, for instance, who is stricken with infantile paralysis, should be able to command the very best of treatment, whether he be of poor or wealthy parents.

Adults, unfortunate enough to have sickness or other physical disorders in the family, should not find it necessary to work the rest of their lives to pay off doctor and hospital bills.

What the answer is to these and many other questions constantly arising, we wouldn't know. We have maintained for a long time, however, that they should come from the medical profession itself. And we hope the Wagner-Murray bill will scare the profession sufficiently to get these answers out without further delay.

Certainly political tinkerers and welfare workers are not qualified to do the job, and it looks to us as if the Senators had been sold a bale of extremely dangerous goods by some fanatic or other, who is one of the group taking advantage of the war to push their theories and fanaticisms onto the national statute books.

One thing all Americans should remember—that regimentation would never come to all groups of citizens at once. It would come group by group, profession by profession, industry by industry.

If the medical profession is established under a Washington commissar, it won't be long until the engineers will be under a dictator also. Then will follow the lawyers, the bankers, the public utilities, railroads, the airlines, and so on down the list.

The medical profession would be chosen first because it is the most vulnerable. If we allow it to be picked off, the rest will be taken over in due course. The time to make a stand is now. The whole principle of free enterprise is at stake. And there is no compromise!—Las Vegas (Nev.), *Review-Journal,* July 28, 1943.

The Rising Generation in Medicine

At no time is it more important to instill into the student mind those high principles which for so many years have guided the practice of medicine. There is, I fear, a growing tendency among students today to regard medicine purely from a materialistic standpoint. Even before the war many of the newly qualified, anxious to convert their acquired knowledge into terms of solid cash, rushed into contract or panel practice without holding any hospital house appointment whatsoever. Since the war the shortage of medical personnel has led to a greater demand for the newly qualified student, and the high fees now paid to temporary locums and assistants cannot but be harmful in the future when the period of present cheap money is past. Another present day aspect of medical student life which personally I much regret is the innovation of political student societies. It is a tradition of British medicine, as it is of the British Red Cross, that our service is independent of political creed. The doctor should be entirely impervious to political influences. His concern is with the great essentials of birth, life and death, which transcend all other considerations, and he should resolutely turn his back to the rival claims of political factions both at home and abroad.—Whitehouse, Sir Beckwith (president of the British Medical Association), The British Tradition of the New Outlook, *Brit. M. J.,* 2:357.

MEDICAL EPONYM

Scanzoni Maneuver

The description of this maneuver appears in "Die geburtshilflichen Operationen [Obstetric Operations]," which was issued by its author, Professor Friedrich Wilhelm von Lichtenfels, Scanzoni (1821-1891), of Würzburg, in the form of a reprint, with revisions, of a portion of the third volume of his *Lehrbuch der Geburtshilfe* [*Textbook of Obstetrics*] (1852). A portion of the translation follows:

"Our procedure under these circumstances is as follows: If the head lies with the brow anterior and turned to the left, so that the longitudinal suture runs in the right diagonal diameter, the left blade is applied in front of the left sacro-iliac synchondrosis, the right behind the right oval window [*eirunder Loche*]. . . . The head is then rotated, by turning the instrument from right to left through one-eighth of a circle, so that the longitudinal suture lies parallel with the transverse diameter of the pelvis.

"Both blades of the forceps are now removed and reapplied so that the left blade lies behind the left oval window, the right in front of the right sacro-iliac joint, whereby the occiput may be drawn under the pubic arch by again rotating the instrument."—R. W. B., in *New England Journal of Medicine.*

Lasting Values.—To have faith in the dignity and worth of the individual man, to believe that it is better to be governed by persuasion than coercion, to believe that fraternal good will is more worthy than a selfish and contentious spirit, to believe that in the long run all values are inseparable from the love of truth and the disinterested research of it, to believe that knowledge and the power it confers should be used to promote the welfare and happiness of all men . . . these are the values which are affirmed by the traditional ideology; they are the values which men have commonly employed to measure the advance of civilization; the values which men have celebrated in the saints and the sages.—From Carl Becker in *Yale Review.*

ORIGINAL ARTICLES

Scientific and General

RHEUMATIC FEVER: ITS INCIDENCE IN THE SOUTHWESTERN STATES*

S. J. McClendon, M. D.
San Diego

The pronouncement has been made frequently that rheumatic fever is most severe and frequent in temperate and cold climates, that "wherever the weather is cold, wet, and changeable, rheumatic fever thrives." In other words, the disease has been said to flourish in those climates in which streptococcic infections commonly thrive. In my discussion, I shall attempt to offer an opinion based on definite clinical evidence that rheumatic fever occurs, with greater frequency than has been realized by reporters in the cardiac field, in tropical and subtropical climates.

Rheumatic fever, with heart disease, is far more frequent than any other cardiac ailment in childhood. It is almost the only form of chronic heart disease occurring in the age group under fourteen, with the exception of congenital heart disease. The etiology of rheumatic fever has been controversial. It is now fairly well conceded that a definite rôle is played in its causation by repeated infections of the beta hemolytic streptococcic group.

The seriousness of rheumatic fever makes it imperative for pediatricians, cardiologists, and educators to study and learn more about the occurrence, symptoms and prevention of the disease. Too little is now known about the incidence because, in most States, the disease is not reportable; and even in those States where it is supposedly done, reports are not made. In discussing this matter recently with the health officers of the southern counties of California, all of them confirmed the usual contention that rheumatic fever does not exist in Southern California.

The manifestations of rheumatic fever are systemic and may be associated with acute carditis, acute polyarthritis, chorea, myalgia, and insidious carditis. The disabling nature of the disease should demand from the medical profession an early diagnosis so that the appropriate treatment may be instituted and thereby morbidity and mortality reduced. The often-quoted figures of Jones,[1] from a ten-year study of 1,000 cases of rheumatic fever, indicate that only one-fourth escape the ravages of the disease, while another one-fourth die. This leaves one-half with residual cardiac damage; of these, one-sixth are totally incapacitated and one-sixth are for all practical purposes completely well, while two-thirds of the remainder are permanent cardiac cripples. There is no exact information which would permit evaluation of what early diagnosis and essential treatment would do in such cases.

Deaths from heart disease under forty years are almost entirely due to rheumatic heart disease. Therefore, we can assume that rheumatic fever contracted in childhood is reflected in the cardiac deaths up to forty years, which comprise 25 per cent of all cardiac deaths. These estimates are sufficient to prove that heart disease in childhood, which is largely rheumatic fever, constitutes an overwhelming public health program. Among school children only, heart disease is the fourth cause of death in the United States. Various estimates place the number of cardiacs in the United States at from 2,000,000 to 3,000,000, and about fifteen out of each 1,000 school children have some form of heart disease. In fifty years the incidence of tuberculosis has declined 50 per cent. The incidence of heart disease has increased 45 per cent. This contrasting picture is the result of better and more widespread dissemination of knowledge regarding tuberculosis, its diagnosis and treatment. Studies of the incidence of heart disease will serve notice to everyone concerned that we have a challenge to reduce the irreparable loss of hours due to the disease, especially in the months of emergency that face us.

AUTHOR'S SERIES

For the purpose implied in the title of this discussion, I have included a group of 112 proved cases of rheumatic fever studied in private practice, and have analyzed the information and reports on eighty-three additional cases admitted to one of the private hospitals in San Diego, California. These patients were all children, ranging in age from three to fifteen years. They were all natives of Southern California or southwestern Arizona, and had not resided outside that area at any time. The purpose of the study was to determine the type, severity and season of onset, and the extent of cardiac damage in these patients. In all of these cases careful histories were taken, with special reference to hereditary, economic and environmental factors and infections, their nature and extent. Examination included thorough physical inspection, together with electrocardiographic studies, fluoroscopic and x-ray examinations of heart and lungs, blood counts and sedimentation rates. The diagnosis was based on the composite picture of these findings.

In this series of 112 cases in private practice, 70 were females and 42 males, showing the usual predominance of females reported by other observers. The onset of the disease in 55 instances was in the spring; summer in 22; fall and winter in 45. The youngest patient was two and one-half years old and the oldest, fifteen years old. The largest number of cases occurred in the age group between six and twelve years. The symptoms varied from those starting with acute polyarthritis, with acute carditis and high fever from the beginning, to the mild, insidious case initiated by joint pains and low-grade fever, with cardiac manifestations and findings later. The course of some was short, with normal heart findings after the attack. In most instances there was evidence of permanent

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* Presented at the annual meeting of the California Heart Association, Los Angeles, May 1, 1943.

valvular heart disease. The average case showed the signs and symptoms for weeks and months. The fever persisted, the appetite remained poor and the color pale, pain in muscles and joints remained, and evidence of cardiac failure occurred at intervals. After variable periods symptoms improved, and appetite, color and weight were regained. The heart findings remained, however, and recurrent, acute exacerbations were evidenced in most cases, with further heart damage resulting. In this series of cases, chorea and rheumatic nodules were rare. Occasional erythemas and abdominal types of onset were found.

REPORT OF CASES

Case 1.—The patient was a female, born on January 12, 1939, a native of Southern California and had always resided in that area. She was the daughter of a physician. There was no family history of rheumatism. The past history revealed many attacks of otitis media and tonsillitis. Examination in January, 1940, showed a pale, underweight female of one year. There was a history of nervousness, irritability, lack of appetite and repeated respiratory infections. There were no joint or muscle pains. Physical examination was negative except for hypertrophied and infected tonsils, underweight, and obvious anemia. The heart was normal. Blood count showed 3½ million red blood cells and a hemoglobin of 72 per cent. Blood sedimentation rate was normal. During the spring of 1942, recurrent colds, sore throats, and otitis media occurred. She was fairly well during the summer of 1942. She had a tonsillectomy and adenoidectomy in August, 1942, from which a good postoperative recovery was made. Her respiratory infections began again in October, in spite of an ideal dietetic management with high vitamin intake, sun baths, and respiratory vaccines. Up to January, 1943, there were no indications of rheumatic fever. At that time there was a sudden onset of severe muscle and joint pains, associated with temperature ranging up to 104 degrees Fahrenheit, with almost immediate cardiac involvement, consisting of tachycardia, cardiac enlargement and a valvular lesion, mitral in type. The first acute attack persisted about two months. The diagnosis was amply proved by the symptoms, course, and obvious carditis. Laboratory findings showed the usual secondary anemia and a markedly increased sedimentation rate, up to 100. Here we have a typical case of acute rheumatic fever developing in a subtropical climate, where economic and housing conditions were ideal, with the consequent development of a chronic, disabling heart disease.

* * *

Case 2.—The patient was a male, ten years of age, born in the Imperial Valley, California, where he had always lived. There was no hereditary factor of rheumatic fever. The patient was first seen in May, 1940. The only pertinent point in the past history was the occurrence of repeated colds and respiratory infections for several years prior to the examination. A tonsillectomy and an adenoidectomy had been done at two years of age. In March, 1940, he had a sudden onset of severe muscle and joint pains, with temperature ranging from 100 to 103 degrees Fahrenheit, loss of weight, sweating, nosebleeds, and lack of appetite were associated. Shortness of breath, pounding of the heart, and a slight edema of the ankles developed shortly. No record of any heart findings or electrocardiographic tracings were made by the attending physician at the time. Physical examination in May, 1940, showed a pale, underweight, male child of ten years. The positive physical findings were largely cardiac, consisting of definite evidence of cardiac enlargement by fluoroscopic and physical examination and a definite harsh systolic murmur with signs of partial heart-block. The electrocardiogram showed a ventricular rate of 65 to 70, irregular. The P-R interval varied from 0.16 seconds to almost simultaneous occurrence with the QRS wave, and at times there was no P wave preceding the QRS complex. The blood picture showed secondary anemia, and the sedimentation rate was 36. Observations at regular intervals have shown a complete clearing of the heart-block. The cardiac enlargement has persisted, and a permanent mitral heart lesion has developed.

* * *

Case 3.—The patient was a female, seven years of age. She had been born in the Imperial Valley and had lived there for the seven years of her life. The family history and environmental history were negative. The past history was negative, except for severe measles at two years of age and mild scarlet fever at three years. A tonsillectomy had been performed at three and one-half years because of repeated attacks of tonsillitis, occurring after the scarlet fever. She was first seen in March, 1941. About one month previously she had had a slow, insidious onset of recurrent muscle and joint pains, with fever ranging from 99 to 101 degrees Fahrenheit. She complained of fatigue, did not eat well, slept poorly, and lost some weight. Examination showed a pale, somewhat underweight female child of seven years. The positive findings were mainly cardiac. The heart was slightly enlarged, with definite evidence of a mitral *lesion*; tachycardia and a slight elevation of blood pressure were associated. Electrocardiograms confirmed the physical findings. Low-grade fever was present, as were definite secondary anemia and an increased sedimentation rate.

* * *

Case 4.—The patient was a male, fourteen years old. Born in Yuma, Arizona, he had lived there for four years and in San Diego for the remainder of his fourteen years. The family hereditary story showed a history of rheumatic fever. The father had a rheumatic heart disease, and a brother, four years younger than the patient, had a similar condition. He had had measles, pertussis and scarlet fever, and at the age of eight a tonsillectomy had been performed. He had had psoriasis for ten years. In the spring of 1941, he fell and sustained an injury to his right knee joint, for which the attending physician applied a cast for several weeks. After the removal of the cast, it was noticed that not only was the right knee swollen and tender, but that the left knee and the smaller joints of the fingers and toes began to enlarge and become very tender. Low-grade fever and general malaise were associated. I first saw him in October, 1941, at which time he was completely bedridden, with severe, generalized polyarthritis. His heart was enlarged, with a rapid rate. Associated was the finding of a mitral lesion. These observations were confirmed by his electrocardiogram. The sedimentation rate was increased, and there was marked albuminuria and secondary anemia. Since that time he has run a low temperature, and there have been periods of regression and exacerbation of the joint condition. His heart is permanently damaged.

COMMENT

Similar case histories could be repeated for all the others studied. The rheumatic fever ranged from mild to severe, as has been observed in other climates. Complete analysis of these cases, together with a summation of the findings in the additional eighty-three records checked at a private hospital in Southern California, enables me to offer several comments regarding the incidence and other characteristics of rheumatic fever in the southwestern United States as follows:

1. Acute rheumatic fever and rheumatic carditis are found far more frequently in this area than has been claimed by most observers. The incidence can be charted more accurately if the law requiring reportability of the disease is systematically observed by all of us.

2. The severity of the cardiac complications is approximately as great as in colder and more severe climates.

3. Poor housing and economic conditions do not seem to be contributory factors to the disease in this area.

4. Repeated respiratory and throat infections of a streptococcic type seem to precede the actual onset of the acute attack.

5. The removal of tonsils and adenoids does not seem to alter the incidence of the disease nor does removal act as a prophylaxis.

I trust that stimulation to further studies, especially in children who, after all, are the cardiac problems of later years, may be induced by this and other efforts of a similar nature.

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REFERENCE

1. Jones, T. Duckett: The Natural History of Rheumatic Fever—Ten-Year Study of One Thousand Cases. Presented at the annual symposium of the San Francisco Heart Committee, November 6, 1942.

THE DISPOSITION OF SUBSTANDARD MILITARY PERSONNEL[*]

Colonel William P. Corr
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How to eliminate physically and mentally handicapped soldiers and thereby procure and maintain a dynamic army has been a serious military problem since earliest times.

The disposition of such substandard military personnel was a matter of concern at least as far back as the time of David. Some years after his epic struggle with Goliath, David's home town was burned (I Samuel, Chapter 30), and his two wives, with others, were taken captive and considerable property carried away. "But David pursued, he and four hundred men; for two hundred stayed behind, who were so faint that they could not go over the brook Besor." In other words, about one-third of his six hundred men "were so faint"—or, in our language, so physically or mentally disabled—that they had to be eliminated from the army as unfit.

Exactly how David determined who were so faint and, therefore, incapacitated for his army is not told, but nowadays the job is handled by the doctors. In this era, before men joined the Army, both civilian and Army doctors tried to keep the unfit from becoming soldiers. Many of them were kept out. As proof of that fact, Colonel Leonard G. Rowntree's statistics are presented as given in *The Military Surgeon* of March, 1942.

Table 1.—*Selective Service Induction Rejections*

Cause of Rejection	No.	Percentage
Dental defects	188,000	20.9%
Defective eyes	123,000	13.7%
Cardiovascular	96,000	10.6%
Musculo-skeletal	61,000	6.8%
Venereal	57,000	6.3%
Mental and nervous	57,000	6.3%
Hernia	56,000	6.2%
Defects of ears	41,000	4.6%
Defects of feet	36,000	4.0%
Defective lungs	26,000	2.9%
Miscellaneous	159,000	17.7%
	900,000	100.0%
Illiterates	100,000	
Rejected	1,000,000	(50%)
Accepted	1,000,000	(50%)
	2,000,000	(100%)

SELECTIVE SERVICE REJECTIONS

It will be noted that the figures given in Table 1 were compiled at about the beginning of our entrance into this war. Since then standards have been lowered in order to allow men with minor physical defects to function in limited service capacities.

At about the same time, in March, 1942, we studied our series of cases in order to determine what types of diseases were most difficult to detect on the induction examinations. We found that we had 582 cases and of these, 502 were soldiers discharged on a Certificate of Disability, and 36 by "Section VIII" Board procedure. Sixteen were retired for disability after twenty years of enlisted service and twenty-eight officers were retired for various incapacities.

It should be stated that the enclosed facts and opinions are not official. They are my own and they do not necessarily reflect the opinion of the Surgeon General or the War Department.

ON SOLDIERS DISCHARGED FOR DISABILITY

The following chart is an analysis of the causes and the line of duty status of the 502 soldiers who were discharged on Certificate of Disability.

Table 2.—*Soldiers Discharged on Certificates of Disability*

	No. of Cases	% of Total C. D. D.'s	Line of Duty YES
Nonorganic diseases of central nervous system	251	50.0%	10 (4.0%)
Orthopedic	81	16.1%	12 (14.8%)
General medical	59	11.8%	3 (5.1%)
Eye, ear, nose and throat	38	7.5%	5 (13.2%)
Organic central nervous system	22	4.4%	1 (4.5%)
Cardio-vascular-renal	20	4.0%	6 (30.0%)
Gastro-intestinal	13	2.6%	1 (7.7%)
Tuberculosis, pulmonary	10	2.0%	4 (40.0%)
Miscellaneous	8	1.6%	0 (0.0%)
TOTALS	502	100.0%	42 (8.3%)

COMMENT

These charts reveal that 50 per cent of the first two million men examined were rejected: 45 per cent for physical or nervous difficulties and 5 per cent for illiteracy. One would expect that those who were selected for the Army would be fine physical specimens—and so they were, in general. It is, nevertheless, true that the care and disposition of the unfit in the Army remains a substantial portion of the work of the named general hospitals. To emphasize this point it was conservatively estimated at the time these charts were made (March, 1942) that, of the cases entering our general hospital, at least one out of every three would be discharged from the military service because of physical or mental disability.

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[*] Read before the second general meeting at the seventy-second annual session of the California Medical Association, Los Angeles, May 2-3, 1943.

The opinions and assertions contained herein are the private ones of the writer and are not to be used as official or reflecting the view of the War Department or the war service at large.

It was noted in Colonel Rowntree's figures that only 6.3 per cent of those rejected were kept out of the Army because of nervous and mental diseases. Of those we discharged from the Army for disability, 50 per cent were mental and nervous cases exclusive of the organic central nervous system diseases. One hundred sixty-two men, or approximately one-third of all of these 502 cases, were discharged because of psychoneurosis, and sixty-one were discharged because of psychoses. More recent figures suggest an even higher percentage of mental and nervous diseases. In addition, many cases with organic disease have a surprising amount of accompanying psychoneurotic overlay. The mental and nervous cases are, therefore, the hardest to detect on induction examinations, and they are by far the greatest disability problem in the Army. The same situation is apparently present in every army in every war. Every effort must be made to keep mental and nervous disabilities from undermining the morale of the troops, and from becoming a staggering future pension problem.

THE MEDICAL OFFICER AND THE SUBSTANDARD SOLDIER

Now that we have been introduced to the problem of the substandard soldier statistically, let us join the Army as doctors and get the atmosphere surrounding this matter of disposition.

When a medical officer enters the military service he is usually assigned to duty with one of two large groups. Either he is assigned to duty in the field with troops, in which case his life is largely that of his brother officers in the combat outfits, or he is assigned to one of the fixed hospitals, in which case his life is rather like that of a resident in a civilian hospital.

If one is assigned to duty with troops, the atmosphere is likely to be that of any combat unit in training for action where morale is high and the men are healthy in body and mind. When an illness develops which is sufficiently severe to keep the soldier from doing full duty, he is usually put in a hospital. There is no such thing as light duty in the Army. A soldier either works full time or he is hospitalized.

Let us imagine that a soldier complains of pains in his abdomen so severely or so persistently that his medical officer feels that the soldier cannot do his daily duties efficiently, or that the symptoms call for further investigation. The soldier is probably seen in a dispensary and is then sent to a station hospital or its equivalent.

The doctor in a station hospital who sees this soldier is accustomed to seeing many minor illnesses and occasional grave emergencies. The turnover of patients is considerable, with the great majority soon returning to duty. A certain number require more prolonged study or convalescence. Many of this latter group are transferred to a general hospital for further treatment or disposition. The station hospital functions actively in discharging disabled soldiers from the service. Our hypothetical patient was found to have a story suggesting peptic ulcer, but his x-ray was negative and he was refractory to treatment. He was placed before a board of officers in the station hospital with a view to discharging him from the Army because of his physical disability, but because of the negative x-rays and his unsatisfactory clinical condition he was sent to a general hospital for further investigation, treatment, and disposition.

The doctor in a named or domestic general hospital who will care for this patient is accustomed to seeing a few acute and many chronic illnesses, and an occasional unusual and complicated case. Many of his patients can be returned to duty within a reasonable length of time with an expectation that they will perform satisfactory service. A considerable number, apparently about one-third, cannot be salvaged and must be discharged from the Army. The doctor in a general hospital, coming from civil life, is impressed by the fact that one of his important duties is to estimate as quickly as possible whether or not a particular soldier will be of value to the war effort in the Army or whether he will be more trouble than he is worth. The doctor cannot, as in civil life, continually bolster his patient mentally and physically to permit the soldier to do a part-time job. Many of those discharged from the Army because they cannot adapt themselves to Army life can function very satisfactorily as individuals in civil life and do much to forward the war effort.

ON RETURNING DISABLED SOLDIERS TO CIVIL LIFE

In addition to being an industrious and capable physician, the general hospital doctor in particular must become expert in the matter of disposing of his patients as promptly and as correctly as possible. Let us confront with him the technique involved in discharging a soldier to civil life for a disability. There are several ways to accomplish this, depending upon the disability and the length of service of the soldier.

The soldier with an incapacitating disability must be recommended for discharge by the ward officer. With the approval of the chief or executive of the service, the soldier will then come before some board of officers appointed by the commanding officer of the hospital. This board usually consists of approximately two senior officers and one junior officer. By far the busiest board of officers is the Disability Board, commonly called the C. D. D. Board, which recommends a Certificate of Disability for Discharge in appropriate cases. It is noteworthy that no board of officers does more than recommend. Only when the commanding officer or other specified higher authority approves the findings of a board of officers is the recommendation acted upon.

Our hypothetical patient with the bizarre abdominal symptoms, after careful investigation, was found to be suffering from incapacitating nervous indigestion or, in our terminology, psychoneurosis, chronic, severe, and was "C. D. D.'d" on that basis.

A less common and less desirable exit from the service for the enlisted man is by recommendation of the "Section VIII" Board of Officers, which deals with the chronic alcoholics, the constitutional psychopathic states, the mental deficiency cases and the inapt.

Use is also made of "Section X," which enables certain commanding officers to discharge "for the convenience of the Government" recently inducted limited service soldiers who are obviously unfit for military service. Enlisted men with twenty years or more of military service may be ordered before a special board of officers for consideration of retirement rather than discharge when they have a disability.

DISPOSITION BOARDS OF THE MEDICAL SERVICE

Before an officer is retired he must be examined in a general hospital by a special board of officers called a Disposition Board, which is an advisory board to the commanding officer. This board can recommend that the officer return to full duty, that he be reclassified for limited service, or that he be ordered before a Retiring Board. A Retiring Board consists of two or more medical officers, three or more nonmedical officers, two medical witnesses, and a recorder.

Most soldiers discharged for physical or mental disabilities are given a white, or honorable discharge. If the condition is due to a venereal disease, to chronic alcoholism, or to certain constitutional psychopathic states, a blue discharge or discharge without honor, is usually given. No discharge for disability of any type is ever used as a disciplinary measure. A yellow, or dishonorable discharge is given only after the action of a general court-martial, and it is not given for physical or mental disability.

When a soldier or an officer with an incapacity appears before any of these boards, many general rules, regulations, and factors must be taken into consideration.

The patient must have a disqualifying disability. Excellent guides for determining whether or not a given condition is really incapacitating is gained from such directions as Mobilization Regulations 1-9, and Army Regulations 40-100, 40-105 and 40-110. These and other regulations, circulars, and directives are written in the light of much medical military experience, and one gains a wholesome respect for them. They are used somewhat more strictly on admitting enlisted men and officers into the Army than they are in discharging or retiring men from the service. Clinical judgment is used hand in hand with the regulations.

The ward officer must have the case well worked up clinically. All necessary facts on which to base a decision must be present to enable the Board to reach a fair decision. This is particularly true in the case of the psychoneurotics. A psychiatrist passes on each case diagnosed as psychoneurosis after organic difficulties have been carefully ruled out or evaluated by adequate consultation. Positive evidence of a psychoneurosis is required, as psychoneurosis is not diagnosed merely by exclusion of organic difficulties in an ailing soldier. We find very little malingering, a condition dealt with by courts-martial. We are quite aware that a certain piece of white paper, an honorable discharge, will cure many a backache or limp. We know that when these ex-soldiers arrive home and handle a good job satisfactorily, it may be felt that insufficient consideration was given to his case. Our early reactions were to send such psychoneurotics back to duty or to reclassify them and make them work. We did send them. They did not do much work. And they came back to the hospital. They were called "shell shock" cases in the last war. A variety of names are used in this war. Our term for some of them is "broken blossoms." We are sure that in general these psychoneurotics will do more for the war effort in civil life.

All the necessary evidence must be available to the Board in order for it to settle the line-of-duty status of the patient. A soldier or an officer discharged with a disability incurred in line of duty is entitled to certain pension rights or retirement benefits under the present law. In other words, in cases disabled in line of duty the Government assumes responsibility for the disability. In general, disabilities are said to be in line of duty if they are the result of injuries incurred while on duty or on authorized leave, or when the disability follows an acute illness at any time after induction, or when a chronic mental or physical disease first appears after six months of active service. Disabilities are not in line of duty when they occur as the result of the patient being drunk, absent without leave, or when they are the result of venereal disease. Chronic diseases such as coronary sclerosis, carcinoma, hernia, tuberculosis, or duodenal ulcer, are usually considered to be not in line of duty when the first symptoms appear within the initial six months of active service. At times the line-of-duty status becomes fairly complicated, as does the matter of whether there has been permanent aggravation of a condition considered not in line of duty. Permanent aggravation also carries with it certain financial responsibilities on the part of the Government.

ON TYPES OF MILITARY SERVICE

If possible, officers and enlisted men are placed on limited service rather than retired or discharged. General military service means that he can do any type of duty anywhere he may be sent. Limited military duty means that the enlisted man is physically fit for certain types of active military assignments commensurate with his physical qualifications. It does not mean that he is only fit for part-time or light work. Limited service does mean that he is fit for full duty only under certain climatic or other conditions. Limited service does not necessarily disqualify a man for overseas duty.

There are many other special problems involved in disposing of the substandard military personnel, but enough has probably been said to give a general idea of the work involved in disposing of them. To the layman the term "disabled military personnel" brings to mind those men who have been wounded in battle. Theirs is a special problem and, fortunately, a relatively small one to date. It is, however, governed by the same basic principles.

It has fallen to the lot of some doctors to go out to adventurous fields with long periods of waiting, alternating with sudden excitement and the opportunity to be of incalculable value in saving life and limb at the forefront of battle. The lot of some of us has been to work prosaically in an effort to take care largely of prebattle illnesses and injuries. We feel that it is a very important by-product of this plodding work to help maintain a dynamic army by carefully sifting out the military unfit; or, in the language of David's time, to leave behind those that "were so faint."

Hoff General Hospital.

WOMEN IN INDUSTRY *

A STUDY OF ONE HUNDRED AND THIRTY-FIVE WOMEN WORKING AS RIVETERS IN THE AIRCRAFT INDUSTRIES

William C. Bradbury, M. D.
and
Charles Benjamin S. Evans, M. D.
Santa Monica

According to a recent survey published in the February number of *Fortune* magazine, about twelve and one-half million women were in the war-working force by December of 1942. About three and one-half million more will be needed in 1943, giving a total of about sixteen million women in essential work by the end of this year. A great many of these women are being employed in the aircraft industry. Sixty per cent of the employees in some plants are women already.

With the institution of numerous aircraft plants in California, thousands of women throughout this State are replacing men at this work. It has been said that women are not physically equipped or emotionally stable enough to do all the kinds of work that men can do. This has, naturally, resulted in numerous problems. The solution, for the most part, has been in the hands of the industrial group of physicians whose training and past experience had been chiefly the prevention and treatment of industrial accidents and occupational diseases. There can be little criticism and much praise of the manner in which they have responded to a tremendous task.

On the whole, little interest has been shown in the problem by those in the medical profession not directly connected with this type of work. This is easy to understand, with the ever-increasing volume of private practice. It is for this reason that this paper is being presented in the Section on Gynecology and Obstetrics, rather than in the Section on Industrial Medicine. It is felt that those who, in the past, have been leaders in the field of gynecology and obstetrics should take an active interest in the protection of the health of women who are doing a big part of the winning of this war.

RECOMMENDATIONS OF COUNCIL ON INDUSTRIAL HEALTH

The Committee on the Health of Women in Industry of the Section on Gynecology and Obstetrics, headed by H. Close Hesseltine, made certain preliminary recommendations to the Council on Industrial Health before the Fifth Annual Congress in Chicago in January of this year. The following general statement was made:

> Shortage of manpower and economic pressure necessitate the employment of millions of women in industry. Sufficient medical data are not available to draft final recommendations about the effect of various kinds of employment on the gynecologic or future obstetric health of women. . . . It is common experience in industry that women absent themselves from work more often than men, and that the duration of the individual absences tends regularly to be longer. The available data do not clearly assign the responsibility for this tendency directly to obstetric or gynecologic function (though it has been taken for granted by some) as against ordinary causes of disability which are equally applicable to men. All of these relationships need careful study over an extended period of time.

A review of the literature on the subject confirms the above report. Most articles deal with the subject of women in industry in a general way and few detailed reports are available. There are several surveys on postal clerks made by the United States Public Health Service. Their results indicate that women are absent much more often than men, but that the great majority of the absences are due to upper respiratory infections and other illnesses common to both sexes. Reports from all large centers reveal that a 5 to 15 per cent of workers engaged in war work are daily being reported absent. The normal peacetime estimate is 2 per cent. It has been determined that 35 to 50 per cent of this so-called "absenteeism" is due to physical disabilities.

With the many new types of work being done by women, numerous unusual complaints are being heard. There have been rumors among the women workers that riveting causes "female trouble." Some of the local physicians speak of the condition as "riveters' ovaries." This has stimulated a study of this particular problem to prove it either as a fact or a fictitious rumor, unfounded on true experience and possibly arising as a form of propaganda.

SOURCE OF MATERIAL

One hundred and thirty-five women riveters with pelvic complaints were studied. Some were admitted to the Santa Monica Hospital by private physicians for treatment, and others were examined and studied by one of the authors in a medical group treating plant employees. These were chosen because of the complete work-up of the patients and accurate pathological diagnosis of the operated cases in the hospital. Patients who were pregnant and developed complications were eliminated because of the probable inaccuracy of the history in these cases.

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* Read before the Section on Obstetrics and Gynecology at the seventy-second annual session of the California Medical Association, Los Angeles, May 2-3, 1943.

RECORDED DATA

The following items on each patient were recorded: age, previous occupation, pregnancies, operations, previous pelvic diagnosis, chief complaints, clinical findings on examination or pathological findings at operation.

Due to the prevalence of menstrual complaints, the following record was kept of these cases:

Menstrual history before employment as a riveter, including interval, duration, regularity, clots and dysmenorrhea, menstrual history since employment as a riveter, including interval, duration, regularity, clots and dysmenorrhea.

RESULTS

Tables 1, 2, 3, and 4 give information concerning the results.

Table 1.—*According to Age*
Ages 18-48 Years

Under 20	8	6%
20-29	73	54%
30-39	38	28%
Over 40	16	12%

Table 2.—*According to Occupation*

Occupation—riveters	135	100%	
Previous occupation—			
40		30%	Light work, such as clerks and waitresses
95		70%	Listed as housewives
III—According to Personal History (Illness)			
Previous pelvic operations	30	22%	
Pregnancies	84	62%	1-9 each
Previous pelvic complaints	11	8%	

Table 3.—*Menstrual History After Employment as a Riveter in Relation to the Previous Menstrual History*

Dysmenorrhea before riveting	81	60 %
Increase in clots with menstruation	33	24 %
Increase in dysmenorrhea	46	34 %
Development of interval irregularity	39	36 %
Increase in the duration	75	56 %
Decrease in the duration	3	2.2%
Menorrhagia	54	40 %
Aggravation of menstrual complaints	114	84 %
No change in menstruation	21	15 %

Table 4.—*According to Authors' Diagnoses*

(Clinical and pathological diagnosis of the 135 patients)

Chronic pelvic inflammatory disease	52	38 %
Fibromyomata uteri	33	24 %
Fibros uteri and dysfunctional bleeding	13	9 %
Endometrial hyperplasia	14	10 %
Prolapse, rectocele, cystocele	9	6.5%
Cervical or endometrial polyps	5	3.7%
Endometriosis internal and external	4	3 %
Idiopathic uterine bleeding	4	3 %
Hyperthyroidism	1	7 %

Of the 135 women riveters studied, a pathological pelvic condition was diagnosed in all but five cases. Of the 54 cases of menorrhagia, 50 were examined and a pathological condition discovered in 49. No cause for the bleeding could be determined in two cases seen in the office, and two cases completely worked up in the hospital. The other case was one of hyperthyroidism.

COMMENT AND CONCLUSIONS

This report is preliminary, for it has been difficult to establish controls in the eight months of the investigation. Only probable conclusions can be arrived at at this time. This evidence, based on the study of 135 riveters with pelvic complaints, is offered in support of our contention that pathological pelvic conditions are probably subject to aggravation in riveters. With the exception of five cases, there was definite evidence of previous pelvic pathology before employment as a riveter. The presence of four cases where no cause for the pathological uterine bleeding could be determined is too small a group to suggest probabilities, though the smallness itself infers that riveting probably causes no pathological condition in the pelvis, or at least not frequently. We have no evidence as to the mechanism by which pathological conditions in the pelvis are upset by riveting. There are two outstanding theoretical possibilities. The mechanical vibration directly disturbs the physiology of the ovary, which is already unbalanced by existing disease; or, indirectly, the patient becomes emotionally upset by the constant vibration and noise, and this affects the physiology of menstruation.

We further believe that a good number of manpower hours can be conserved by a careful history and, more important, by an adequate preplacement examination of the pelvis of women workers. Some plants have good preplacement examination routines, including a careful pelvic examination. This should become universal. The number of manpower hours lost in transferring one riveter to another type of work after losing several weeks due to illness is costly. Paul McNutt, Chairman of the War Manpower Commission, says, in speaking of manpower conservation:

> Industry has a bigger task than saving that time lost to prevent diseases and accidents. Your assignment is total conservation of manpower. Like military medicine, it means prevention and restoration. Prevention has the high objective of throwing around the soldier every known health protection to keep him in action. If he does succumb to sickness, accident or enemy attack, the duty is to restore him to action as quickly as science, skill and nature permit. Your task is to do the same for the men and women in our war industries. . . . Our industrial army without whom the United Nations cannot win."

It has been worked out that the next large group of women to be taken into the war industries will be drawn from married women with children over sixteen years of age. This means that fewer cases of pelvic inflammatory disease and abortions will be seen, and more cases of pelvic relaxations, dysfunctional uterine bleeding, carcinoma of the cervix, and the menopausal syndrome. These pathological conditions should be corrected before employment. Many of these patients are now under the care of their family doctor. An effort should be made to have these patients have an adequate preplacement examination. This should be our problem and responsibility to see that this is done. Industrial plants have a list of specialists who are consulted when needed. Doctor Hesseltine has recommended that a gynecologist and obstetrician should be added to this list where a substantial number of women are employed. We think that this is a step in the right direction. For example, very few plants require routine interval check-ups, and yet here is an unparalleled opportunity to reduce the mortality rate of carcinoma. Industrial physicians are doing an excellent work in protecting the health and welfare of the nation's large number of industrial employees. They need the experienced and trained specialist to control and study the problems of women workers, that adequate rules and regulations can be drawn up for their protection and well-being.

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CANCER OF THE UTERUS: THE VAGINAL SMEAR IN ITS DIAGNOSIS*

Herbert F. Traut, M. D.
San Francisco
and
George N. Papanicolaou, M. D.
New York

A NEW method for detecting the presence of uterine cancer is based upon the well-established vaginal smear technique. Much use has been made of vaginal smears in the study of the reproductive cycle in laboratory animals, as well as in women. Cells from the various epithelial surfaces of the uterine canal, the cervix and the vagina undergo changes in morphology and staining properties which are sufficiently characteristic to enable one to evaluate much of the normal or abnormal hormonal physiology responsible for the variable cell patterns. It is only necessary to collect the exfoliated cells from the posterior vaginal fornix; spread them upon a clean glass slide, fix them in an alcohol and ether solution, stain them, and they are ready for study under the microscope.[2]

In the course of routine studies of human vaginal smears, Papanicolaou discovered that not only were the normal cells shed and hence demonstrable in the vaginal smears, but also many pathological cells could be found, among them those of cancer.

AUTHORS' STUDIES

To determine the relationship of cancer cells in the vaginal smear to the incidence of malignant disease in the uterus, as demonstrable by clinical methods and the biopsy technique, Papanicolaou and Traut have collaborated in a study covering three years at the Cornell Medical College. Vaginal smears, many thousands, were made and studied, with the result that, in their hands, the method has been demonstrated to have a decided advantage in that it enabled them to detect cancer without even a minor surgical procedure. The preparation of vaginal smears is easy, may be quickly carried out, and can be repeated at frequent intervals whenever desirable.

It is particularly valuable in the diagnosis of very early carcinoma of the cervix and fundus—even before such lesions can be demonstrated by the biopsy method—with the single exception of adenoma malignum.

METHOD USED

The method, therefore, will be described in some detail in the hope that others may become interested in learning how the malignant cells can be recognized. An adequate description cannot be attempted, however, for lack of space. The interested reader is, therefore, referred to a more complete work which is to be available shortly.[3]

The malignant epithelial cells exfoliate from the surface of neoplastic growths, much as do normal cells. They then float downward into the vaginal fornix, where they accumulate and become mixed with normal cells of epithelial and blood origin, as well as with mucus, bacteria, parasites and cellular débris. The rate of exfoliation of the malignant cells seems to be dependent upon the rate of growth of the neoplasm and its size. Young, small, and slow-growing lesions, therefore, usually shed only few cells, whereas a large and rapidly growing lesion will ordinarily contribute relatively rich showers of characteristic cellular elements.

Meticulous scrutiny of the stained smear preparations is an important essential as well, as that such searching may be done by a person trained in the details of this type of cellular diagnosis. An atlas[3] with colored illustrations has been prepared and will shortly be available to aid those interested in learning the method. The details of the staining technique will also be given in all the details necessary to duplicate the color reactions as shown.

DIFFERENTIATION

In brief, the differentiation of the malignant cell from those of benign origins is based upon changes in the size, shape, staining reactions, and the characteristics of the chromatin elements in the nucleus, the nucleoli, and the cytoplasm. Variations in size, with lobulated, crenated, or elongated nuclei are most suggestive. If, in addition, the chromatin shows fragmentation, granulation, or displacement to one or other pole of the nucleus with one or more nucleoli, the probabilities of malignancy are great. If, in addition, one sees numbers of such cells in close proximity to one another so that the above criteria can be established by accurate comparison, a presumptive diagnosis of malignancy can be made. The word "presumptive" is used advisedly, as we do not feel one should ever use this method as the basis for an absolute diagnosis. Each of the different types of carcinoma, such as those of squamous or glandular origin, shows a great variety of changes, such that the microscopist must be well acquainted with the many cell forms. Description of the many variations is not only difficult but practically impossible; therefore, resort must be made to illustrations, or to the study of the smears themselves, if one is to become proficient or reliable in their evaluation.

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* From the Department of Obstetrics and Gynecology, University of California Medical School, and the Department of Anatomy, Cornell Medical College.

Read before the Section on Obstetrics and Gynecology at the seventy-second annual session of the California Medical Association, Los Angeles, May 2-3, 1943.

The vaginal smear presumptive diagnosis should be substantiated by use of the biopsy. It might be inquired, then, what is the particular value of the vaginal smear in the diagnosis of cancer of the uterus? The answer is that the vaginal smear can be applied to larger numbers of women because of its simplicity and ease of application, whereas the biopsy can only be used when one has at hand all the facilities for a minor surgical procedure. Furthermore, the vaginal smear can be made to reveal the presence of cancer when it cannot be demonstrated by any other means. In addition, the vaginal smear may be made without trauma of the parts, and thus the dangers of dissemination by way of open lymphatics are avoided. For these and other reasons it is of distinct value in addition to the possibilities offered by the other methods of diagnosis available to us. This is especially true because it reveals *early* cancer. That is, it demonstrates the lesion at a time when cure is easy and may be said to be certain.

AUTHORS' SERIES

In the course of several thousand examinations, Doctors Papanicolaou and Traut found 193 instances of carcinoma of the uterus—about 126 lesions involving the cervix and of both squamous and the adenocarcinomatous varieties; the rest, sixty-seven, carcinomas of the fundus. The smear showed the presence of cancer of the cervix in all but 1.3 per cent of the instances when it was demonstrable by biopsy. The failures to diagnose were due to postradiational effects with partial healing in one case and, in another, to excessive bleeding which was so profuse that it washed all the cells out of the vagina. However, there were thirteen instances of adenocarcinoma revealed for the first time by the vaginal smear when no other clinical procedure had sufficed to make the diagnosis. Some of these were very early lesions.

COMMENT

It is clear, therefore, that the vaginal smear is the best of any single available method. And that as far as early carcinoma of the cervix and silent carcinoma of the fundus are concerned, it is far superior to biopsy.

However, in view of the fact that the method is subject to some fallacious deductions, and also because it will be a long time before any considerable number of microscopists can be trained to a degree of dependability in diagnosis, we recommend the use of the vaginal smear as an "indicator method," and the biopsy as the final step necessary to the making of the final diagnosis.

We feel that the application of this method will bring about a great increase in the number of early diagnoses of carcinoma of the uterus and that as a result a great improvement in the "cure rate" of carcinoma of the uterus may occur. In addition, many unsuspected older lesions of the cervical canal and fundus of the uterus will be discovered; and, although these are not so amenable to treatment as the early lesions, they will be brought under the influence of therapeutic procedures sooner than would otherwise have occurred, with improvement in results in this group as well.

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MEDICAL EPONYMS

Politzer Bag

Dr. Adam Politzer (1835-1920), while *Docent* in otology at the University of Vienna, presented a discussion, "Über ein neues Heilverfahren gegen Schwerhörigkeit in Folge von Unwegsamkeit der Eustachischen Ohrtrompete [On a New Therapeutic Procedure in Deafness due to Blocking of the Eustachian Tube]," in the *Wiener medizinische Wochenschrift* (13:84-87, 102-104, 117-119 and 148-152, 1863). A portion of the translation follows:

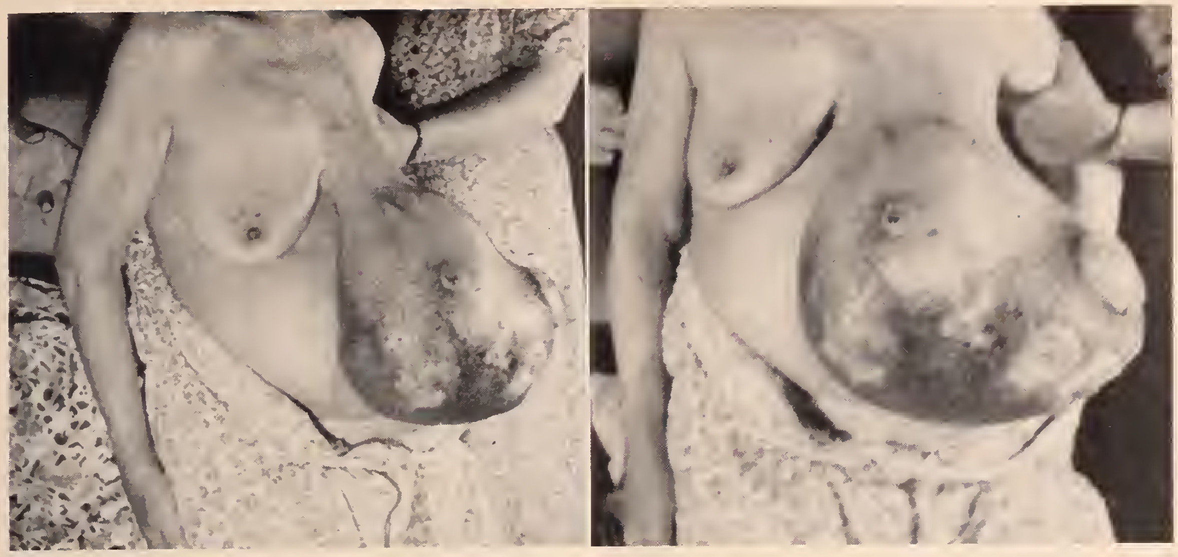
"The seated patient holds a little water in his mouth . . . and is told beforehand to swallow it at a given signal. The instrument used consists of a straight or slightly curved metal tube shaped like a catheter; or better, a rubber tube of rather large caliber, connected with a pear-shaped rubber bag about twice as big as a man's fist. The physician, standing preferably at the patient's right side, inserts the anterior end of the tube 1.0 cm. into the proper nostril, compresses the ala nasi (so that no air can pass over the instrument) with his left thumb and index finger, and with his right hand vigorously expresses air from the bag into the nose while the patient swallows."—R. W. B., in *New England Journal of Medicine.*

* * *

Eustace Smith Sign

This sign, although not unanimously accepted as valid, is still frequently referred to. It was described by Dr. Eustace Smith (1835-1914), physician of the East London Children's Hospital, in a communication entitled, "On the Diagnosis of Enlarged Bronchial Glands in Children" (*Lancet,* 2:240, 1875). He writes:

"The symptoms by which enlargement of the bronchial glands can be distinguished . . . are all pressure signs due to the encroachment of the swollen body upon the parts around. . . . At an earlier period, and before the enlargement has become . . . great . . . much assistance can be gained from the following experiment. If the child be made to bend back the head so that his face becomes almost horizontal and the eyes look straight upwards at the ceiling above him, a venous hum, varying in intensity according to the size of the diseased glands, is heard with the stethoscope placed upon the upper bone of the sternum. As the chin is now slowly depressed, the hum becomes less loudly audible, and ceases some time before the head is brought back again into the ordinary position."—R. W. B., in *New England Journal of Medicine.*



Figs. 1 and 2.—Malignant tumor of left breast.

MALIGNANT TUMOR OF BREAST

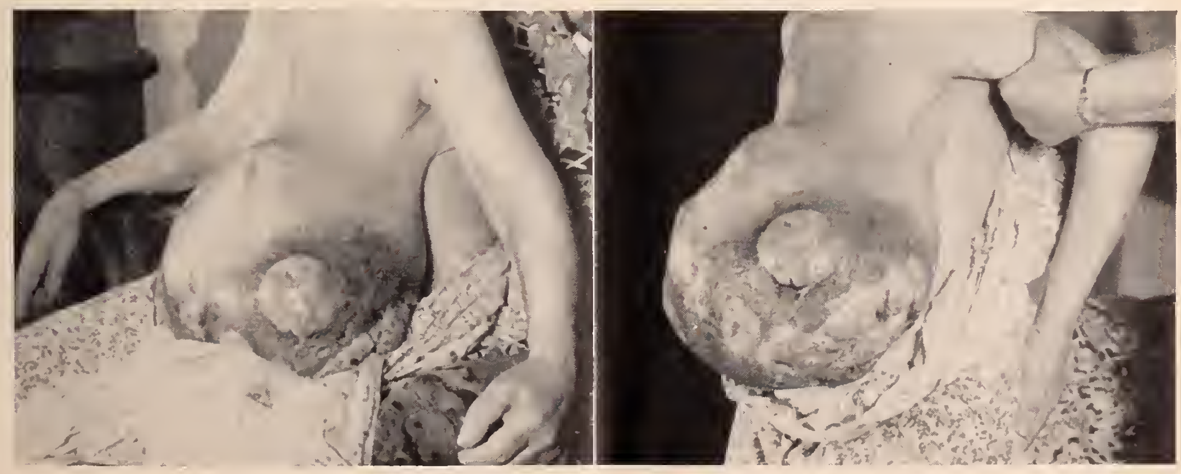
E. G. Motley, M. D.
and
D. A. Harwood, M. D.*
Santa Ana

Mrs. Anna K., widow, age 67, height 5 feet, 3 inches, weight 170 pounds. Born in Germany of poor parentage, family consisting of nine children. An uncle in America sent for her and two brothers, and they came to America and settled in Kansas. Father died at age 85 and mother at age 67. The other children in Germany she does not know about; but, as far as she knows, the two brothers in America are alive. She has grown up and lived on a farm in Kansas until about three years ago, when she came to California. She had the usual diseases of childhood without any special complications. She had pneumonia when about 40 years old, but general health has been good.

She was married at age 24, has three children living and well, one baby stillborn. She nursed her children, and after the youngest was weaned she noticed a small lump in the left breast which was about the size of a small walnut. She thought it had something to do with "caking" of the breast, so said nothing about it to anyone. However, it seemed to grow as time went on and gradually became considerably larger. Then she was afraid to say anything about it, as she dreaded any operation, having known a woman who had died following a breast amputation. It continued to increase in size, and about a year ago the surface broke on the most dependent part. Her daughter came for some advice as to what to do with it, but said her mother refused to allow any doctor to see her or treat her.

The denuded and broken-down surface spread and the necrotic area developed into a more extensive surface and a serosanguineous-purulent discharge became very copious and foul-smelling, and she required considerable attention from the family. Finally, a neighbor persuaded her to have medical advice and so she came under supervision.

She entered St. Joseph's Hospital on the evening of May 2, 1943, and on the following morning, under light anesthesia of intravenous pentothalsodium, Dr. D. A. Harwood and Dr. E. G. Motley removed this entire mass. By lifting it up so the base was held taut, clamps were placed across the base and it was removed. The removed mass weighed twenty-two pounds. Vessels were clamped and tied and retention sutures put in and the skin closed with dermal sutures. There was an uneventful recovery and the patient left the hospital in four days. She is quite well now, no edema of the arm, and no pain or soreness. She is very active again (June, 1943), gaining in weight and strength; feels better than she has for many years.



Figs. 3 and 4.—Malignant tumor of left breast.

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* Editor's Note.—The death of Dr. D. A. Harwood, president of the Orange County Medical Society, occurred on July 17, 1943. Obituary tribute appears in this issue.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL NOTICE

Proposed Amendment to Article IV, Section 1 (c) of the Constitution of the California Medical Association. (See June, 1943, "California and Western Medicine," Reference No. 5, on page 349.)

Section 1 (c) of Article IV of the Constitution of the California Medical Association is hereby amended by adding, immediately after the first paragraph contained in said Section 1 (c), a full new paragraph:

If an application for retired membership is submitted by a component medical society within the calendar year immediately succeeding the last calendar year in which the recommended applicant was an active member in good standing, the Council shall have authority to act on such application as though it had been submitted in the preceding calendar year during which active membership existed.

So that the said Section 1 (c) of Article IV will, therefore, read:

(c) Retired Members

Qualifications.—Retired members of the California Medical Association shall be elected by the Council on the recommendation of any component county society from those active members thereof who cease the practice of medicine for reasons satisfactory to such component county society and the Council, and who shall have been active members of the Association for ten years or more prior thereto.

If an application for retired membership is submitted by a component medical society within the calendar year immediately succeeding the last calendar year in which the recommended applicant was an active member in good standing, the Council shall have authority to act on such application as though it had been submitted in the preceding calendar year during which active membership existed.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Armed Forces Must Have Six Thousand More Physicians by January 1[*]

The Medical Profession Is Expected to Fully Meet the Responsibility That Has Been Placed On It

The armed forces must have six thousand additional physicians by January 1, 1944, *The Journal of the American Medical Association* reports in an editorial on page 1016 in its August 7 issue. *The Journal* says:

"At a conference of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, held on July 31, with the War Participation Committee of the American Medical Association and in the presence of Mr. Paul V. McNutt, chairman of the War Manpower Commission, and representatives of the Army and Navy medical departments and the Public Health Service, it became apparent that the medical profession must produce toward the winning of the war an additional six thousand physicians for the armed forces before January 1, 1944. Pursuant to a realization of this objective, a directive has gone to the generals in command of the various service commands authorizing them to induct into the service physicians between the ages of 38 and 45 who have been declared available by the Directing Board of the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians and who are otherwise subject to Selective Service.

[†] For complete roster of officers, see advertising pages 2, 4, and 6.

[*] For full text of the War Manpower Commission directive of June 7, 1943, concerning physicians under age of 45, appeared in the July issue of CALIFORNIA AND WESTERN MEDICINE, on page 78. Editorial comment in the same issue, on page 2.

"The needs of the armed forces are real. The members of the War Participation Committee raised with the representatives of the various governmental agencies all the questions that have from time to time challenged the need; the challenge seems to have been met effectively. Indeed, the intimation was made clear that the needs of the armed forces will be met by specific regulations of the Selective Service Administration or the enactment of necessary legislation if required. All physicians up to 45 years of age who have been indicated as available have, therefore, placed on them now the responsibility for an immediate decision as to their enlistment with the armed forces. The need is so positive that questions of essentiality of men in positions of teaching and research and in industrial medicine are likely to be rigidly reviewed in the near future with a view to extracting from civilian life everyone that can be spared.

"As the war continues and intensifies, new needs for the services of the medical profession become apparent. An army in motion and one engaged in the kind of aggressive combat that now concerns our armed forces needs physicians in even greater numbers than have heretofore been demanded. Many thousands of interned aliens and prisoners are now the burden of the United States and must be given medical care.

"If there is any physician who still hesitates under these circumstances, he should realize the added advantage to him of accepting now the commission that is proffered. Should it become necessary in the near future, as seems quite likely, to enlist new activity by the Selective Service Administration and the Officers' Procurement Service to bring in the six thousand physicians that are so certainly required, those recruited by that technique will inevitably begin their service with the minimum commission that is offered, namely, that of first lieutenant. Until that technique is installed, the men of special competence and of years beyond those of the recent graduate have the assurance of careful consideration and a commission more nearly in accord with age and experience.

"The call here made has the approval of the Directing Board of the Procurement and Assignment Service and of the War Participation Committee of the American Medical Association. The medical profession may well be proud of the fact that it has been the only group given, by directive of the President, the responsibility of maintaining service in civilian life and at the same time supplying the needs of the armed forces. Let us not fail in meeting fully the trust that has been placed upon us."—*The Journal of the American Medical Association*, August 7, 1943.

Burns and Wound Infections in Air Raid Casualties: New Recommendations

The Medical Division of the Office of Civilian Defense has revised its pamphlet, "Treatment of Burns and Prevention of Wound Infections," to incorporate new techniques that have been developed within the past year. The recommendations in this pamphlet are based on recent directions of the Committee on Chemotherapeutic and Other Agents and the Subcommittee on Burns of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. Originally drawn up by these committees for the armed forces, the recommendations have been modified to adapt them to the problems involved in the treatment of civilian casualties.

Recommendations for the use of sulfonamides are accompanied by the observation that these drugs must be used more cautiously in the treatment of civilian wounds than is necessary in the care of military casualties for the following reasons:

"The injured may include individuals of all ages and with various types of preëxisting disease, instead of a selected group of healthy young males. The possibility of toxic effects is therefore greatly enhanced. Moreover, it is assumed that in civilian injuries, hospitalization will be possible in a relatively short time, whereas in military operations such is not always the case. This usually makes it possible to postpone all consideration of chemotherapy until the injured have been hospitalized. It is then possible to administer sulfonamides with better safeguards and to consider such contraindications as other pathological conditions or known sensitivity to individual drugs. The dangers of dehydration can also be better prevented or overcome under such circumstances."

In a discussion of intra-abdominal wounds leading to perforation of the hollow viscera, the revised pamphlet advises sodium sulfadiazine as the drug of choice for parenteral administration, which is considered preferable to oral therapy during the first forty-eight hours. Sulfanilamide was recommended in the previous edition. Concentrated solutions of sodium sulfadiazine are not recommended for subcutaneous or intramuscular routes, but it is pointed out that weak solutions (0.5 per cent) may be used with little danger of sloughing of the tissues.

Special emphasis is placed on the danger of giving sulfonamide drugs to a patient who is not voiding normally (over 1,000 c.c. per day).

"Should circumstances require sulfonamide administration in the presence of inadequate urinary output, the urine should be watched for evidence of renal damage and the dosage of drug adjusted so that a blood concentration, as evidenced by daily determinations, not to exceed 10 milligram per cent, is maintained," the pamphlet warns. "If further diminution of the urinary output occurs, administration of the drug should be stopped immediately and fluids should be forced orally, if possible, and by means of glucose and water (5 per cent in sterile distilled water), intravenously if necessary. If anuria due to bilateral obstruction of the ureters develops, ureteral catheterization and lavage of the renal pelves may be required."

The emergency care of burns is outlined as follows:

"Whenever casualties with extensive burns can be admitted to hospitals without delay, and definitive treatment can be instituted promptly, morphine sulphate, one-half grain, should be administered at the scene of the incident and no local therapy applied to the burned area except sterile gauze to exposed surfaces to prevent infection."

The most notable change in the Office of Civilian Defense pamphlet is the withdrawal of the recommendation of the use of ointments or jellies containing tannic acid in the first-aid treatment of burns. The new advice given is that when definitive care cannot be carried out within two hours, the patient should receive sufficient morphine to relieve pain (not less than one-half grain, except in patients with lung and bronchial damage, the very old or the very young); and the burned surfaces should be covered with sterile boric acid ointment or petrolatum over which one or two layers of gauze of fine mesh (44) is to be smoothly applied. Over this dressing thick sterile gauze or sterile cotton waste is to be placed and the entire dressing is to be bandaged firmly, but not tightly. Substitution of jelly containing 5 per cent sulfathiazole in water-soluble base, which is supplied in the Office of Civilian Defense carrying case A for Mobile Medical Teams, is permissible.

The discussion of definitive treatment of burns has been expanded to stress the necessity for administration of large amounts of plasma.

"In patients with severe burns, quantities up to twelve units or more may be required in the first twenty-four hours," it is pointed out. "To the patient in critical condition, plasma must be given rapidly (as much as 500 c.c. in ten minutes may be necessary) and not allowed to flow drop by drop. It must never be administered by any other than the intravenous route. Syringe injection may be used. If facilities for hematocrit determinations are available, the following general rule can be used for guidance regarding the amount of plasma required. For each point that the hematocrit is above 50 per cent cells, at least 100 c.c. of plasma should be administered. If clinically satisfactory results are not obtained with this dosage, larger quantities should be given."

A footnote points out that rapid administration of intravenous fluids may be dangerous to cardiac patients and that the physician's judgment will have to determine the amount as well as the rate of administration in such cases.

The pamphlet describes "open" and "closed" treatment for burns. The "open" treatment which is now considered the treatment of choice and is especially recommended for treatment of burns of the hands, face, feet, perineum and genitalia, consists essentially of the application of boric acid ointment or petrolatum, with pressure dressings. Such dressings can often be left in place twelve or fourteen days.

The "closed" treatment, which is the tanning or eschar method, is particularly indicated in extensive "flash" or second-degree burns of the trunk. This method is recommended only if the following conditions are present: (1) If not more than twenty-four hours have elapsed; (2) if the burned area has not been grossly contaminated; (3) if strict surgical asepsis is employed in the preparation of the burned surface; and (4) if coagulation is rapidly accomplished, *i. e.,* by combined use of tannic acid and silver nitrate. The method of tanning is described as in the original edition of the pamphlet.

In the new directions, additional emphasis is placed on masking of both the patient and his attendants in order to minimize the danger of secondary infection.

Office of Civilian Defense Advises Gas Cleansing Stations at Hospitals

Hospitals should make complete plans for the immediate establishment, when needed, of "gas cleansing stations" for the care of injured persons who have been exposed to war gases, the Medical Division of the Office of Civilian Defense advises. Large communities should establish at least one gas cleansing station without delay for training purposes.

The Office of Civilian Defense recommends that the term "gas cleansing" be used to describe the procedure of removing vesicant liquids from persons and that the term "decontamination" be reserved for areas and objects.

The primary purpose of gas cleansing stations is the protection of hospitals and casualty stations and their staffs and patients from contamination by injured persons who have been exposed to vesicant agents. Contaminated persons who are not disabled are expected to cleanse themselves in the nearest private home or in other local facilities.

Existing facilities in casualty receiving hospitals must be converted into gas cleansing stations, it is pointed out, since under present conditions of scarcity of materials and man power, construction of new facilities is generally not justified. Hospital facilities that should prove suitable are: hydrotherapy rooms, nurses' or internes' locker and shower rooms, part of the outpatient department, garages or other separate structures. In the event these are not available, facilities to care for persons who are both injured and contaminated must be arranged in schools, gymnasiums, swimming pools, shower rooms, clubhouses, and community centers.

Cleansing stations should be equipped to take care of one-third to one-half of the hourly casualty receiving capacity of the hospital to be served, the Office of Civilian Defense recommends. The professional staff will consist of mobile medical teams assigned when the station is activated, supplemented by additional attendants from the Emergency Medical Service. In addition to cleansing and emergency treatment, the staff of the gas cleansing station will assist in undressing the injured, moving stretchers, caring for clothing and valuables, maintaining supplies and dressing wounds.

It is recommended that cleansing stations be established at or near hospitals and casualty stations which they are to serve. Every hospital that may be required to handle an appreciable number of casualties should have access to such cleansing station facilities.

The local Chief of Emergency Medical Service is responsible for the development of these stations, with the advice of the senior gas officer of the community.—*The Ohio State Medical Journal,* July.

Concerning Physicians Essential for Civilian Practice

A boxed card with black-face caption, appearing in the Tulare *Times* of July 9, contained the following text:

NOTICE TO THE PUBLIC

Every person under the age of forty-five in Tulare County practicing any branch of the healing art, as licensed by the State of California, has in his possession, if he has been made essential to the medical needs of his community, a letter stating the facts and that he is not available for military service. This letter will be signed by the Chairman of the Tulare County Procurement and Assignment Committee for physicians and surgeons.

TULARE COUNTY MEDICAL SOCIETY.

Six Thousand Service M. D.'s Needed

Chicago, Aug. 5.—(UP).—The armed forces must have six thousand additional physicians by January 1, *The Journal of the American Medical Association* announced today.

To achieve this goal, generals in command of the various service commands have been authorized to induct physicians between the ages of 38 and 45 who have been declared available by the directing Board of the Procurement and Assignment Service for physicians, dentists, and veterinarians, *The Journal* said.—San Francisco *News,* August 5.

Health Protection for Welders and Burners

Although the health of welders is, in general, good, there are some health hazards associated with welding, and those may be minimized by proper precautions. This bulletin contains a general summary of the more important occupational health problems of welders and the measures necessary to safeguard their health.

Eye Irritations.—Flying particles of slag or hot metal, and welding rays may irritate the eyes. Such injuries can be largely prevented by using the proper type of goggle. Safety goggles will protect the eyes from flying particles. Colored glass will prevent "flash burns." These colors have been standardized, and shades recommended for particular types of work are commercially available. The lighter shades protect from occasional indirect exposures, but will not protect from the direct glare of a welding arc. These should be worn underneath the welders' hoods, to afford protection while inspecting welds. The higher shades are used in welding helmets and goggles to protect the eyes from direct exposure while burning or welding. Metal or canvas shields should be provided around welding operations wherever practicable, and care should be taken not to weld while an unprotected worker is facing the arc.

Burns.—Welding rays may cause an artificial sunburn. This may be prevented by protective clothing and helmets.

Metal Poisoning.—Zinc fumes from welding on galvanized iron may cause metal-fume fever; lead fumes from lead cutting, or burning of lead-painted metal may cause lead poisoning. Metal poisonings can be prevented by local exhaust equipment so constructed as to remove the fumes at their source (exhaust openings must be placed within a few inches of the operator), and by the use of approved metal fume respirators or air line respirators.

Gas Poisoning.—Gases produced by the arc or acetylene torch may cause injury, but this ordinarily occurs only when welding is done in an enclosed space. Under such conditions an airline—or air-supplied respirator should be worn by the welder, unless adequate exhaust and ventilating provisions have been made.

OCD Plan for Emergency Medical Service in Industrial Plants

Every plant medical department should prepare a "disaster operations plan" to provide adequate medical service in case of a plant catastrophe involving large numbers of casualties. This is the advice presented in a new bulletin, "Emergency Medical Service for Industrial Plants," issued by the Medical Division of the Office of Civilian Defense (M-7047)....

Pointing out that plant medical departments are not ordinarily staffed or equipped to provide medical service for the large number of casualties which may occur in a major disaster, the bulletin outlines arrangements which should be made to assure adequate medical care at such times.

The disaster operations plan should provide for necessary first aid care at the site of the incident, for adequate ambulance service, and for hospitalization of the seriously injured, the bulletin advises.

Provision must first be made for casualty stations. Several sites should be selected, in order that alternative locations may be used in case those of first choice are destroyed or rendered unserviceable. An additional site outside the plant should be selected for use in the event of extensive damage to the plant, such as might occur in a bombing or explosion.

The importance of identification and records is especially emphasized in the bulletin.

"In any disaster confusion will be inevitable," it is pointed out. "It will be difficult, without adequate records, to identify the seriously injured and the dead and to determine the number and names of the missing. The uninjured as well as the injured should be accounted for. A record should be made of every person who leaves the plant. The record should indicate the places to which the injured have been taken."

In a consideration of transportation, the bulletin recommends that arrangements be made with the local Chief of Emergency Medical Service to insure that ambulances under his direction will be made available to the plant should a disaster involve the entire community. Similarly, any ambulance facilities owned by the plant should be made available to the local Chief if they are not required at the plant.

Present plans for the hospitalization of industrial accident victims are likely to be grossly inadequate in the event of a major plant catastrophe, the bulletin declares. Large numbers of patients should not be sent to one hospital, if other hospitals are available. To provide quick and efficient service to injured persons, casualties should be distributed among various hospitals. Arrangements must be made with the local Chief of Emergency Medical Service for the admission of casualties to community hospitals, all of which will be under his supervision during a major emergency.

A prerequisite to the entire plan of mutual aid between a plant and a community is a definite understanding that members of the Emergency Medical Service will be admitted promptly to a plant in an emergency. To assist plant managers to carry out their duty in keeping unauthorized persons out of war production plants and to facilitate the admission of physicians when they are needed, the Service Commands of the Army are conducting investigations of the key personnel of the Emergency Medical Service. Personnel investigated and approved by the Service Command, will receive identification cards from the Office of Civilian Defense.

The bulletin sketches the organization and operation of protective services in a community, and the over-all protective services recommended for industrial plants. It also outlines the program of federal compensation for injuries to Civilian Defense workers and explains how this plan applies to industrial workers. A bibliography of pertinent material is included.

Government Chart: "Operation of Emergency Medical and Rescue Services"

An interesting chart was issued in August by the United States Office of Civilian Defense, Washington, D. C., as OCD Publication 7022.

The chart is sufficiently diagrammatic to warrant its placement on the bulletin boards of hospitals and casualty stations. Its inspection easily and rapidly orients the reader on the exact steps of procedure in caring for injured persons in case of an "incident." Its text follows:

"The *incident* (first illustration) is reported by the *warden* (second illustration) to the *control center* (third illustration). Local chiefs of rescue and emergency medical services at the center dispatch to the scene of the incident:

From *rescue depot* (fourth illustration), a rescue squad.

From *hospital* (fifth illustration) or *casualty station* (sixth illustration), one ambulance and one sitting-case car with one mobile medical team.

Ambulance takes major casualties to casualty receiving hospital. Sitting-case car takes minor casualties to near-by casualty station. (*Other services are dispatched similarly by the control center.*) Evacuees from hospital are removed by large bus or truck ambulances to *emergency base hospital* (seventh illustration) in rural area.

Central registry of *Emergency Welfare Service* (eighth illustration) received casualty information from hospitals, casualty stations, and morgues."

More New Homes: War-Working Alameda Opens Another Federal Housing Project

In war-working, industrially booming Alameda, 1,200 desperate workers have applied for apartments with the Alameda Housing Authority.

But there *is* a Housing Authority in Alameda which is building war apartments. And what does it mean to these war-working house seekers?

They Are Moving In

In cold, solid figures, it means that 4,902 dwellings are planned for them. Families have moved in and filled up ninety-five of these dwellings in the Pacific Project.

Opening up now is the Chipman Project. Twenty-two families are living there and more are coming in as each building is finished. Completely occupied, the project will be housing 760 certified Alameda war workers.

The Encinal Project, to accommodate 1,240 families, and the Webster Project, which will house 400, will open very soon.

Still in the planning stage, with no buildings up, are the Webster Number 2 Project, which will house 360 workers, and another project, now nameless, which will house 1,040.

Ground is now being broken for the Atlantic Trailer Park, which will accommodate 206 trailer families.

And that's all. Because Alameda will have no ground space left for other dwellings when these are completed.

There you have living quarters. As for schools, stores, child-care service and recreation, they, too, have been considered.

Health Service

As for health, the California Physicians' Service, which provides complete medical and hospital care on a coöperative basis and 24-hour doctor's care will be available.

The California Physicians' Service will go into effect as soon as 90 per cent of the tenants of any one project sign up for its services.—San Francisco *Chronicle*, June 4.

Medical Journals—For Colleagues in Military Service

In former issues, editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy, and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The addresses of the three libraries follow:

University of California Medical Library, The Medical center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals via "Railway Express Agency," collect, to: California Medical Association Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261). The "Railway Express Agency" will call for packages and will collect costs from the California Medical Association. The Postgraduate Committee will forward to camps.

* * *

The covering letter, which follows, is sent forward with each shipment:

CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, San Francisco

To the Medical Officer in Command

At Army, Navy, or Air Force Station located in California
at: ——————, California.

From: *California Medical Association Postgraduate Committee.*

Subject: *Medical Literature* (To be shipped to your camp).

Dear Doctor:

We shall shortly send to you, by prepaid mail or express, as per the above address, some medical journals or books.

These are not late editions, but they are, after all, medical literature.

When received by you, you are at liberty to place or dispose of them as you see fit.

They are contributions received from medical colleagues in civilian practice, and from the three medical libraries in California: University of California Medical Library (Medical Center, San Francisco); Stanford (Lane Library at 2398 Sacramento Street, San Francisco); Los Angeles County (Barlow Medical Library, 634 South Westlake, Los Angeles); in response to requests made in CALIFORNIA AND WESTERN MEDICINE in its issues of: September, on pages 169 and 201; October, on pages 230 and 250; November, on pages 286 and 315. (The facilities of these medical libraries are available to your staff members for "packet service.")

At some hospital stations, there is an ample supply of medical literature available. At others of the newer camps, there is practically none.

Your hospital station has also been placed on the complimentary mailing list of CALIFORNIA AND WESTERN MEDICINE.

We trust you understand the spirit in which these parcels are sent. They go forward to your respective camps with the good wishes of your civilian colleagues. If the undersigned can be of service, feel free to inform us.

Cordially and fraternally yours,

CALIFORNIA MEDICAL ASSOCIATION POSTGRADUATE COMMITTEE,
By GEORGE H. KRESS, M. D., *Secretary.*

Military Clippings.—Some news items of a military nature from the daily press follow:

15,000 Wounded Removed by Air

Chicago, July 15.—(INS)—Seven thousand stretcher cases were evacuated by airplane from battle areas in Algeria in April, the *Journal of the American Medical Association* reported today in a story from its London correspondent.

More than 15,000 wounded were taken to Oran, Algiers or Gibraltar by aircraft equipped as ambulances, according to the correspondent.—Los Angeles *Examiner,* July 16.

Scarcity of Doctors

With the number of women doctors in this country now numbering many thousands, it seems strange that so few of them are in army service. Although they fought for the privilege, they are hardly enlisting at all. A report issued on July 1 indicated that only four had actually received officers' commissions. It is suggested at Washington that the women physicians do not realize how much they are needed, with the army 7,000 short of the requirement for essential care of soldiers.

The army heads emphasize the fact that no distinction is made between men and women doctors, and both are wanted. The women have the same rights as the men, and must meet the same professional standards, and are assigned wherever they are most needed. Doctors may have to be rationed.

One reason, presumably, why the women are slow to join the army medical service, is that with so many men doctors already gone to join the armed services there is a great lack of physicians on the home front, and the women think it their duty to serve on that front. They might be right about it.—Berkeley *Gazette,* July 20.

Army Reports Quick New Venereal Disease Cure

Brigham (Utah), June 23.—(AP)—Rapid strides in the postwar cure of gonorrhea through use of a new yeast-like fungus called penicillin was envisioned today by doctors at the Army's Bushnell Hospital.

Lieut. Col. Henry G. Hollenberg, chief of the surgical service at the hospital, and Lieut. Col. Frank B. Queen, chief of the laboratory, reported the new drug—available only to the Army—cured twelve of fourteen cases of gonorrhea within thirty-six hours and satisfactory results were obtained in the others.

Other Drugs Failed

The doctors said all fourteen of the infected men had failed to respond to other treatment, despite an average hospitalization of fifty-two days and the use of many other drugs, including the sulfa type.

Hollenberg admitted the results were astounding, but was reluctant to predict what effect the new discovery would have on the prevalency of venereal disease when the medicine becomes available to the public after the war.

Queen, however, said the Army's tests at Bushnell spoke for themselves.

Queen said use of the drug throughout the Army, when it becomes available in such quantities, would reduce hospitalization from weeks to a few hours or days. . . . —San Francisco *Examiner,* June 24.

Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Doctors desiring to go into the Army may have their papers prepared and receive orders for physical examination from the Officer Procurement Service, 328 Flood Building, San Francisco, in charge.

From any of the fourteen southern counties, they may apply to the Officer Procurement Service, 1418 U. S. Post Office and Courthouse Building, Los Angeles, Major M. L. Murrell, in charge. Telephone: MAdison 7411, Extension 684.

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U. S. N. The Senior Medical Officer is Capt. Philip K. Gilman, U. S. N. R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone: EXbrook 3386, Local 46.

The Naval Office of Procurement for the southern section of California is in charge of Admiral A. Johnson, U. S. N. The Senior Medical Officer is Captain John C. Ruddock, U. S. N. R. The office is located at 411 West Fifth Street, N. W. Corner of Hill, Los Angeles. Telephone: MIchigan 8641.

Army Draft Cut; 287,000 Women Needed

Washington, June 18.—The Army as of now plans a net increase of only 1,020,473 persons in its uniformed personnel during the twelve months starting July 1, and more than a quarter of that increase will be women.

The figures appeared to foretell a sharp decrease in the rate of inductions, and possibly a postponement of the time when general drafting of fathers will start. . . .

Major General H. K. Loughry, Army chief of finance, presented a table showing that the Army is planning to have to pay a peak of 8,233,083 uniformed persons during the 1944 fiscal year. That peak load includes 7,801,224 men—603,022 officers and 7,198,202 enlisted men; 375,000 WACs, including 40,202 officers; 51,177 women nurses, 2,900 female dietitians and 2,782 women physical therapy aides.

The increases contemplated by those figures above the peak for the current fiscal year—a peak which undoubtedly will be June 30, the last day of the year—included 698,202 enlisted men and 35,178 men officers; 28,406 WAC officers and 236,561 enlisted WACs; 19,278 nurses, 1,452 dietitians and 1,396 physical therapy aides.

Thus, Selective Service will be called upon to furnish 733,380 men after June 30, plus replacements for men killed in battle or who leave the service for other reasons. It was noted, however, that since the table included pay for all uniformed Army personnel, nonfatal casualties apparently will not be replaced above the increases noted.

Recent testimony by naval officers before another appropriations subcommittee in connection with the Navy supply bill revealed that it plans a net increase of 802,397 persons in its uniformed personnel, including women's reserves. It included a net increase of 775,192 men.

The increases of 775,192 men for the Navy and 733,380 men for the Army mean that 1,508,672 men—plus, presumably, replacements for fatalities—will be called into the two services during the next year.

That would be an average of approximately 125,000 men a month. But since the Army presumably will take most of its additional men during the next six months, the induction rate may well level off at 100,000 or less a month after January 1.—San Francisco *News,* June 18.

Three Physicians "Buddies" in Army

The unusual circumstance of three men who were associated closely in civilian life being assigned to the same place in Army service is noted in the case of Dr. Philip Corr, Dr. Ray B. McCarty and Dr. E. D. Quick, all of Riverside, now at Hoff General Hospital in Santa Barbara.

Doctor Corr, who went into the Army about two years ago as a major, recently was promoted to the rank of full colonel. He is director of the medical division and chief of medical service.

Major McCarty is chief of the general surgery section, while Captain Quick is chief of the out-patient department. The families of all three men now are living in Santa Barbara. Colonel Corr and Major McCarty were on the program of the California Medical Association this week in Los Angeles.

Colonel Corr has been at the base hospital ever since it was established to take care of service men stationed in the Southland.—Riverside *Enterprise,* June 12.

Navy Lease on Two Big Hotels Confirmed

Yosemite, Sun Valley to Get War Wounded, McIntire Says

Rear Admiral Ross T. McIntire, Navy surgeon general and White House physician, on June 2 confirmed reports that the Navy will lease Ahwanee Hotel in Yosemite Valley and properties in Sun Valley, Idaho, as quarters for convalescent wounded.

Men will begin moving into Sun Valley's 1,400 beds within two weeks, and the Ahwanee's 1,000 accommodations are immediately available, he said.

On a tour of hospital bases, and to "observe certain patients from the South Pacific," Admiral McIntire said he was "seeing a very different type of case from those of the last war."

"This is due in part to the violence of this war," he said. "Another of our problems is malaria, and it is very, very serious. Not only do we have it in the Pacific, the Army shares it in Africa. A high number of men are being immobilized by it.

"While we had 8 per cent fatalities among wound cases in World War I, our record as far as deaths from battle wounds are concerned now is only about 2.1 per cent.

"This is due, I think, in part to the way we handle cases, with no more long trips by ambulance. We have better methods for shock treatment, with the blood substitutes, and the sulfa drugs. In addition, officers and men know or are taught first aid."

Commenting on lowering of Navy physical standards for the first time, as ordered recently, Admiral McIntire said men with defects in sight, hearing, or in their legs and hands, may be used on limited duty, but not as a combat class.

Admiral McIntire, who planned to visit Mare Island and Treasure Island today, will complete his bay area inspection tomorrow, leaving here tomorrow night.—San Francisco *Call-Bulletin,* June 2.

Life Saver in Tunisia: Blood Plasma Led in Keeping Death Rate Low

Chicago, June 7.—Major General Norman T. Kirk, Surgeon General of the Army, told the American Medical Association House of Delegates today that the American wounded death rate in Tunisia was "unbelievably low."

The rate was two-and-one-half to three-and-one-half per cent, for the Americans' first campaign before they moved north to attack Bizerta. These are the first official figures. They are higher than in some other fighting, but are miraculous because of the long distances the wounded had to be carried. In World War I under like conditions deaths would have been 15 to 18 per cent.

General Kirk was personally through the Tunisian campaign until after the German surrender. He was appointed Surgeon General after his return to the United States, June 1.

In Tunisia, said General Kirk, the wounded had to be carried on the average eight to twenty miles through mountains to the first medical stations, and after that another 650 miles by ambulance to evacuation hospitals. Later there was another 400 to 500 miles back to base hospitals.

Planes, which carried war supplies to the front, brought back 13,000 men to hospitals, including both battle casualties and the sick.

Sulfa drugs were definitely not the first reason for the saving of lives, General Kirk asserted.

The foremost life saver was plasma, the dried blood extract which millions of Americans have been giving the Red Cross for nearly two years. Plasma saved shock and bleeding, and without that General Kirk said many men would have died before they could reach medical care.

Second in life saving was surgery, which cleaned up the wounds to reduce risk of infection. In third place were the sulfa drugs, aiding to minimize infections.

In this southern campaign an unbelievable record was a total of only seventy-seven cases of bone infection. That trouble afflicted 75 per cent of the wounded in previous wars. The seventy-seven cases were an almost astronomically small fraction of 1 per cent of wounded.

Gas gangrene, another killer, caused just one death, and there were only twelve cases altogether.—Howard W. Blakeslee in San Francisco *Chronicle,* June 8.

Hotel Will Be Ready Soon as Army Hospital

Conversion of the Vista del Arroyo Hotel in Pasadena into an Army hospital is rapidly nearing completion and the first patients are expected to be received about July 1, it has been announced by Lieutenant Colonel W. C. Williams, executive officer. . . . The hospital will provide care for soldiers stationed at Camp Santa Anita and other area Army posts, it was stated.

Colonel Williams, a veteran of thirty-three years' service in the Army Hospital Administration, predicted that the hospital, surrounded by broad terraces, swimming pools and other recreational facilities, probably will become one of the most important convalescing units in the country.

Staff members who have reported for duty include First Lieutenant Dora A. Noble, principal chief nurse; Major Gordon K. Smith, chief of surgical services; Captain George T. LeClercq, chief of x-ray services; Major Perry J. Melnick, chief of laboratory services, and Lieutenant Colonel Rolph P. Chessal, chief of dental services.—Los Angeles *Times,* June 3.

Evacuation from Battle

Wonder has been expressed as to what the Allied armies in Tunisia can do to feed and care for the great host of over 200,000 enemy captives. To do this is a normal function of armies and is planned for well in advance.

In army operations, there are two great services that go on behind the fighting lines. One is the forward movement of food, ammunition, reinforcements, replacements, and it is called "the Service of Supply." At the same time, a rearward movement takes place, organized carefully and fully provided for. It is called "evacuation." It is the daily transport from the fighting front to positions far in the rear, of the wounded, the sick, of guns and equipment that require repair, captive property that can be salvaged; and it is the transport of prisoners.

The whole object of a well organized system of evacuation is to free the fighting forces of the impediment of broken men and broken material. It cannot be done too soon. It is normally done every night following battle. . . .

* * *

The other rearward movement of personnel are the casualties—the wounded, disabled, the men too sick to continue. This matter of medical evacuation is a whole subject in itself. It requires special organization and a series of different units working from the firing line far back into the rear.

Accompanying every battalion into action are surgeons and a small group of Medical Corps men. It is their business to give prompt aid to the men who fall. It is dangerous and heroic work, done under fire. The immediate care given to a man who is shot by a bullet or torn by a fragment of a shell is temporary only enough to stop his bleeding, to apply a tourniquet or an antiseptic bandage.

Instructions may differ now, but in the first World War, we were taught to leave the wounded man alone until he recovered from shock—let him lie quietly for a while, provided that his bleeding be staunched, that his thirst be slaked and his position made comfortable.

Soldiers today are trained not to fall out of the ranks to take care of a stricken comrade. They must keep advancing, and keep up their fire. The old picture of soldiers helping a wounded comrade to the rear represents obsolete form. It impairs the attack. It accomplishes no good.

* * *

From their position where they lie on the ground, wounded men are carried on stretchers by special units, called "bearer companies." They are carried a short distance rearward to positions where field ambulances are met. Here a man's injury is reëxamined, the bandage adjusted, if necessary. He may be given a stimulant, light food, an opiate, an antitetanus injection. Then he is moved back, this time by an "ambulance unit," formerly horse-drawn, now motorized, and carried some distance to the rear beyond the reach of artillery shelling, to the field hospital of the division. Even here, only necessary attention, immediately required, is given by the medical officers.

From this hospital in the field, wounded are evacuated as promptly as possible, by medical agencies sent forward from the Army. At this point, too, or even sooner, the nature of the man's injury is determined. If his wound is slight, he may even be marked for return to duty. If he can walk, he is a "walking patient," or a "sitting patient," or a "prone patient," according to his injury.

This process of sifting wounded and separating them according to their injuries is called by a French word that we picked up in the first World War, triage.

* * *

Medical regiments are a part of the troops that accompany all armies. There are "hospital regiments," some of them able to set up under canvas hundreds of cot beds, "surgical regiments" which can operate on wounded men whose condition is too serious to allow further immediate evacuation. Back of this organization are "base hospitals," "convalescent hospitals," and so on.

The system in use in the American Army is called the Letterman System and it has a rather curious history. Doctor Letterman was the surgeon general of the Army of the Potomac in the Civil War. His experience in the early battles of that war taught him that special organization was necessary if wounded men were to be saved and cured, and if the fighting forces were to be promptly relieved of their care and their presence. Letterman worked out a system. It was first used, I believe, in the Battle of Antietam, where the casualties were very large.—(Letterman Hospital in the Presidio at San Francisco was named in honor of Doctor Letterman.)—From an article by Major General David Prescott Barrows, military authority and former president of the University of California, in the San Francisco *Examiner*, May 21.

Learn by the experience of others; your own may come too late.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

How to Obtain a Physician in a Family Emergency

County Society Issues Recommendations to the Public Through a Press Statement

Under the above caption, the Westchester, New York, Medical Bulletin of July, 1943, issued a press statement that may have suggestive value to component county societies in California.

Westchester families were urged on June 7 to take steps to make sure they may be able to obtain necessary medical care in the event of a family emergency. The suggestion was in the form of a statement issued by the county medical society, in which the public was urged to communicate with the local hospitals if the family physician is not available at a time of emergency need. The statement follows:

"The Westchester County Medical Society has received reports indicating that occasionally Westchester families have encountered difficulty in obtaining the services of a physician, especially in the late evening or early morning hours. While there is a real shortage of physicians in Westchester, owing to the fact that one-third of the county's normal complement of doctors is serving with the armed forces, nevertheless, there are enough physicians in civil practice to care for all normal needs if the public will continue to coöperate with the profession and inform itself of the plans that have been made to meet emergencies.

"Most of the younger physicians normally available for work during the night are in the Army and Navy. The men remaining in civilian practice are older and more handicapped physically. They now are working harder than ever during the day-time hours, which makes it necessary for them to conserve their energy as far as possible and to avoid unnecessary interruptions of their rest. Local groups of physicians in all parts of the county are aware of this problem and have taken steps to make certain that everyone shall be able to reach a doctor when he needs one. In general, emergency arrangements are centered in the community hospital.

"The County Medical Society recommends the following steps:

"(1) Every person should become acquainted with some family physician in his community. The names of general practitioners, pediatricians or other specialists can be obtained by consulting the local hospital or the office of the Westchester County Medical Society in White Plains.

"(2) In emergency, if the family physician is not available the family should telephone the local hospital. If the emergency is acute the family may request the hospital to get in touch with a local physician and arrange with him to make the call at once. If the situation is not urgent, the hospital may be asked to give the names of several practitioners serving on the attending or courtesy staff of the hospital, and the patient himself can make the contact with the doctor.

"(3) If the patient lives in one of the larger communities, he may communicate with the local medical exchange or professional building where the telephone operator can put the patient into immediate contact with one of a number of local physicians.

"(4) During daytime business hours, the office of the Westchester County Medical Society will give advice on these matters. The society will not recommend individual physicians, but will give lists of physicians, either in general practice or in the various specialties in any part of the county.

"(5) In emergency, the worst way to reach a local physician is to start calling all the physicians listed in the local telephone directory. Many of them are in military service, many others are specialists not normally available for general practice, some will be out of town. In general, if your family doctor is not available, the easiest way to reach a doctor quickly is by calling the local hospital."

Poliomyelitis Precautions

Although infantile paralysis cases have increased alarmingly in California this summer, the disease is not considered at epidemic stage yet by medical authorities. However, there is every reason for utmost precautions on the part of the public to prevent its becoming so.

A few simple rules are advised by California State Health Director Wilton L. Halverson as follows:

Call a doctor at once on discovery of such symptoms as stiff neck, sore throat, sore muscles, headache, rise in temperature, or nausea.

Keep children away from crowds.

Avoid undue exposure to heat, cold, and fatigue.

Get plenty of sleep and food to build resistance.

These should be easy to remember and observe. Strict adherence to them may mean the saving of many child lives and avoid the maiming of many young bodies.—San Francisco *News,* July 13. (See also items on page 152.)

Concerning Poliomyelitis

This is the season for the start of infantile paralysis epidemics. The National Foundation has compiled the following suggestions which may be helpful to residents of areas where poliomyelitis is on the march.

During an outbreak of infantile paralysis, avoid overtiring and extreme fatigue from strenuous exercise. Avoid sudden chilling, such as would come from a plunge into extremely cold water on a very hot day.

Keep children away from large groups. Parents should reduce the number of associations between children and other persons. The policy should be one of staying at home. Discourage visiting and avoid parties, gatherings, crowds, and travel. It is the opinion of medical authorities that tonsil operations should be delayed until an outbreak is over.

Be alert to early signs of illness or changes in the normal state of health, especially in your children. Do not assume that a stomach upset or signs of a cold are of no importance. These may be among the first symptoms of infantile paralysis.

All children and adults sick with unexplained fever should be put to bed and isolated, pending medical diagnosis.

Call your physician at the first sign of sickness. Early diagnosis of any illness gives greater hope for recovery. In infantile paralysis, early good treatment may save lives and prevent permanent damage.

Don't become hysterical if cases occur in your neighborhood. The medical profession and the health department will be using every known safeguard. Poliomyelitis is a disease caused by a filterable virus. During an epidemic many persons become infected with this virus, but only a small proportion are made ill. In a still smaller proportion, the illness is accompanied by muscular weakness or some degree of paralysis. Not more than one individual in every 3,000 or 4,000 has a paralytic attack. In other words, in a community there are many more unrecognized infections or "carriers" of the virus than reported cases of the disease.

The virus may be given off from an infected person in droplets from the throat or in fecal excretions or in both. The ordinary conditions of everyday associations between people in a family or in a community afford opportunity for the virus to pass from one individual to another. This passage may be reduced, in some degree, or prevented by careful attention to personal cleanliness and hygienic habits that should always be observed.

While it is possible that the virus may at times be conveyed through the medium of polluted water or milk, or by flies contaminated with fecal material, these modes of transmission are thought to be rare. Nevertheless, be sure to use milk and water that are known to be safe. And maintain community sanitation at a high level at all times.

Attempts to stop the spread of the virus by closing places where people congregate have been unsuccessful. The resultant disturbance to community life is a disadvantage. Therefore, orders requiring the closure of schools, movies, churches, and swimming pools ordinarily are not worth while.

The spread of the virus in your community cannot be entirely prevented, nor can the disease be "cured," in the strict sense of the word, but much more can be done for the patient. So give your support to the public health authorities in their efforts to lessen the penalties which it imposes on some of its victims.—*National Foundation News.*

How to Select Your Doctor

How to choose a reliable, competent physician is a problem made more acute these days, with many of the strongest and best-trained doctors going—or already gone—into the armed services.

Also vast changes in population centers have come about with the development of war industries, and many people are finding themselves in totally new environments, without such familiar landmarks around them as their family doctors.

Consult Agencies

It is more important than ever that the working civilian population get satisfactory medical care, and that intelligent distinction between competent medical practitioners and quacks be made.

There are several impersonal agencies of information about doctors available to the questing public. Obviously, the license to practice is one of these. So are membership in county medical societies and permission to use the facilities of an accredited hospital. And, finally, the records of the American Medical Association in Chicago may be consulted and give full objective data about all its members.

Ethics Strict

Information of this sort may also be gotten from the secretary of the local medical society, which is a branch of the American Medical Association.

There are certain signals which the layman can observe in making his choice of a doctor. He should beware one who claims extravagantly successful cures with "secret" medicines. The various healing cults are not full-fledged physicians, and advertising is not acceptable practice among reputable physicians.

Doctors who talk glibly and persuasively may frequently mask incompetence with too much "charm," and those who strive to frighten patients and then mulct them with exorbitant fees are likewise not to be trusted. Last of all, it is important to consider the term of residence and quarters of one's doctor. Doctors who travel about rapidly from town to town are likely to do so out of necessity.

One of the best and most direct ways to receive recommendations as to a doctor lies in calling the director of the nearest accredited hospital and asking for such information. It is also possible, through the various files and publications of the American Medical Association for a doctor in one community to recommend one physician or several in another community.

With these suggestions at hand, the patient can make his own selection further on the basis of personality preference, since agreeable personal relationship between patient and physician is extremely important in promoting satisfactory recovery.

The patient may go even more deeply into the matter of personal recommendation, and inquire among his acquaintances as to who stands particularly high among the physicians themselves of the community. Mere size of practice is no reliable criterion of a doctor's excellence, since the art of salesmanship may be the major factor here rather than the art of healing.—Dr. Thomas Masters, in San Francisco *News*, June 25.

Government Builds Big Hotel for Workers

Men and Women Both Living at Dormitory

A war-time city, complete from living quarters to barber shop, has been constructed by the Federal Government in the Los Angeles harbor area to house workers who have poured into the shipyards by the thousands to build transports, cargo vessels, and warships at the fastest rate in history.

A dormitory with rooms for 3,000 workers, the $2,341,437 project is known as Wilmington Hall. It is operated as a hotel by the Los Angeles Housing Authority, and until a short time ago was housing only men. Increasing employment of women in the big yards near by received official recognition early in May, when rooms for 500 persons were opened to women.

Largest Hotel in World

With 2,126 double and single rooms, all furnished, Wilmington Hall has been termed the largest hotel in the world. Its sixty-seven buildings spread over nearly forty acres of land. Besides actual living quarters, they include a community center with theater, gymnasium, music room, cafeteria, library, lounges, barber shop, laundry and cleaning shop, community store, and infirmary. A staff of 185 men and women gives complete hotel service.

Construction of Wilmington Hall was started May 30, 1942, three days after the Los Angeles Housing Authority had signed an agreement with the Federal Public Housing Authority to build and manage the place for the duration of the war.

The architect, Lewis Eugene Wilson, designed the hall as a war baby throughout. Most of the buildings are walled with plywood—not a critical material at that time—with board siding on the outside. Plywood does the job of both inside and outside walls in the community buildings where uncovered studs rib the exterior. Such substitute materials as plastic shower heads, faucet handles, tubing, and fittings were used wherever possible.

Walled With Plywood

Management methods also were designed from the war angle. Shipyard work and overtime puts a strain on a person's health. So a health plan to give each resident who needs it, diagnosis, surgery, and hospitalization was set up by the Housing Authority through a contract with the California Physicians' Service. Weekly charge of $5.60 for a single room and $4.10 per person for a double includes the health service. The 32-bed infirmary is staffed by ten nurses, a physician and two dentists.

Morale of the residents is another problem. Many men living in Wilmington Hall have left their families in Texas, Arkansas, Oklahoma, Nebraska or Iowa to migrate to the turbulent war center. A daily schedule of entertainment and recreation is worked out by a staff of five community service aides to help keep up the spirits of these war workers.

A big auditorium, 75 by 150 feet and shaped like an oil drum cut in half, can seat 1,218 persons for motion picture shows twice a week and stage shows at least once a month. When seats are moved out, the room becomes either a ballroom or a gymnasium. Five acres of land are devoted to baseball diamonds, handball courts, horseshoe pits, and archery ranges. A folksy newspaper is put out weekly by the residents..

The Housing Authority's agreement with FPHA lasts only for the duration of the war. When its necessity has passed, Wilmington Hall will either be torn down or sold to private bidders. It was constructed as expendable housing to meet a shelter need that resulted from America's demand for more ships than had ever been built before in the shortest possible time.—Wilmington *Press*, May 8.

Civilians Will Get Only 20 Per Cent of New Physicians

Only 20 per cent of the medical graduates each year can now be spared for care of civilians. The others will go into the military medical corps as long as the war lasts.

This prospect was sketched to the House of Delegates of the American Medical Association in Chicago on June 8 by Dr. James E. Paulin of Atlanta, the Association's new president.

The yearly total of new civilian physicians he estimated at about 1,200. To this he added about 600 who are being retired each year from military service. Against this the doctors who are left, mostly men over 45, are dying at the rate of 2,500 a year.

Urges Planning

This leaves a deficit of about 700 a year. To meet this, and the big shortage due to nearly half the active doctors already in military service, Doctor Paulin said plans should be made now for better use of the older physicians who have not been very active in medical practice.

It is the hope of organized medicine to have one doctor for each 1,500 persons in the United States. This compares with an average of two to four per thousand in many areas, and is much better than some rural communities which have seldom or never had more than one doctor for 2,500 to 3,000 persons.

Doctors' Studies Curbed

The war has cut off the ordinary opportunities of physicians to keep up with advances and discoveries in medicine. To meet this, Doctor Paulin said the service hospitals of the Army and Navy all over the country are being opened to graduate medical meetings where doctors can learn and exchange new information.

He said that for the duration there is likely to be a falling off in studies on many diseases, particularly arteriosclerosis, heart disease, arthritis, cancer, and mental diseases. He recommended that doctors returning from war service be encouraged to undertake investigation of these diseases.—Fresno *Bee*, June 9.

Taking Dentifrice Ads to the Cleaners

Advertising men have done such a good job of selling dentifrices that millions of American medicine cabinets are cluttered with tubes and cans and bottles, bought in the belief that their contents will lend a sparkle to teeth, and claims have been so extravagant that the Federal Trade Commission, whose job it is to protect the public against falsification in advertising, has had to crack down several times during the past few years.

It has issued complaints against . . .

These representations are not only false and deceptive, charged the Federal Trade Commission last April, but they unfairly defame and disparage competing products. While most dentifrices contain mild abrasives, they do not cut cavities nor harm the teeth. . . .

In proceeding against these various companies, the Federal Trade Commission was not opposing the legitimate advertising of their products. The Commission is determined, however, that manufacturers shall cease misrepresenting them. . . .

The best way to clean your teeth is to give them a good brushing, using an up-and-down motion so that you reach all exposed surfaces. The Council on Dental Therapeutics says that an inexpensive tooth-cleaning material can be made at home: one part of table salt plus three parts of baking soda. There is no objection to the use of most dentifrices, if you prefer their taste to that of salt and soda, but do not deceive yourself by supposing that they possess any magic powers. The truth about dentifrices is simply that whether you lay them on like a ribbon, dust them on or pour them on, none is more than an aid to the brush in cleaning the teeth, none has therapeutic value of any substantial kind, and none stands out as better than the others to any important degree.—*Reader's Digest,* August, 1943.

Draft Discloses Rate of Syphilis

Congress was recently informed that in the examination of men, aged 21 through 35, for the armed services, 47.7 of each 1,000 were found to have syphilis and that the prevalence among negroes in one Southern State ran to 405.9 in each 1,000.

The figures, which were based on a study of the first 2,000,000 drafted men examined in forty-four States, were given to the House Appropriations Committee by the Public Health Service.

Dr. Thomas Parran, Surgeon-General, said that rejections ran to 46,000 in each 1,000,000 men because of syphilis and 15,000 of each 1,000,000 due to gonorrhea infection. If this ratio held through the examination of 10,000,000 men, there would be more than 610,000 rejections due to venereal diseases.

Venereal Disease Control

The importance of venereal disease control in the war emergency again has been recognized by the Congress by its appropriation for the fifth year of funds to implement the LaFollette-Bulwinkle Venereal Disease Control Act of 1938. As recommended in the President's budget, the sum of $12,500,000 was appropriated for the fiscal year beginning July 1 for the U. S. Public Health Service and for federal aid to the states in the fight against syphilis and gonorrhea. This is the same amount expended for the fiscal year just closed. Progress is thus assured for the coming year. Under the leadership of Surgeon-General Thomas Parran, coöperating with the Army, Navy, Division of Social Protection, and the American Social Hygiene Association, the Service will aid in making new records, it is believed, in "the lowest wartime venereal disease rate in history."

Do Welding Rays Cause Sterility?

There seems to be a fairly widespread rumor that arc welding causes damage to the reproductive organs so that the welder, male or female, is unable to have children.

However, the ultra-violet rays which are given off in arc welding have very little power of penetration. Ordinary clothing absorbs a good part of the rays, and the rest are absorbed in the topmost layers of the skin. None of the rays get through to the vital organs of reproduction.

The welding arc also produces infra-red rays, the kind that are produced by the "baking lamps" in doctors' offices. These rays can penetrate somewhat deeper than the ultra-violet rays of the welding arc, but as everyone knows who has had a baking-lamp treatment, they produce a good deal of heat as well. Before they could cause any real damage to the vital organs, a definite sensation of burning would be noticed and the effect of the burning would be quite uncomfortable.

The only rays which are known to be capable of causing sterility are x-rays. Experiments have been conducted in industrial plants to determine whether x-rays are emitted by the welding arc. Welders carried dental x-ray films in their pockets for weeks at a time to test whether the electric arc produced x-rays, but the results failed to indicate even the slightest amount of x-ray exposure.

Lead Poisoning

It is very unlikely that the welding arc of itself can cause sterility. On the other hand, welders are also subject to metal-fume fever and to lead or manganese poisoning. Lead poisoning is a hazard which occurs when metals covered with lead paint are cut by either the electric arc or the oxyacetylene flame.

The intense heat causes the formation of lead fumes which are capable of producing rapid and severe poisoning of the welder. This has become a real danger in the shipyards, where surfaces already painted with red lead are being welded into place in order to speed up production. Unless proper precautions are taken, cases of serious lead poisoning are likely to result.

Lead poisoning can and does cause damage to the vital sexual tissues, resulting in sterility and miscarriages. Usually, however, lead poisoning causes other symptoms as well, such as fatigue, listlessness, poor appetite, constipation and abdominal pain.

In summary, it appears to be highly improbable for arc welding rays to damage the reproductive organs. On the other hand, if welding fumes are not properly controlled, it is possible that lead poisoning or metal-fume fever may have a bad effect.

The answer, therefore, lies in the effective control of welding fumes.—San Francisco *People's World,* May 15.

Design for Tomorrow's Maternity Care*

During our 320-odd years of colonial and national life there has never been such need for man or woman power as there is today. The life and well-being of every man, woman, and child suddenly becomes important and we find ourselves ill-prepared and ill-equipped to meet all of the passing needs of medical care. Our first objective in medical care in this country must be to provide effectively and universally for the protection of maternity and the rearing of children who will be healthy in body and mind. We cannot begin too soon to plot out our plan of operation, our campaign for the next ten years.

What is it then that we must do if we are to assure good maternity care to every mother?

First of all, we have to make up our collective minds as to the basic philosophy on which we will proceed. Do we as a nation intend to provide good care for every mother regardless of her place of residence, her race, and her financial status, or are we going to be content with the makeshift plan we have today under which some mothers get the best care that is known anywhere in the world while others get along with no skilled assistance of any sort? When the people understand thoroughly what can and should be done, I do not doubt that they will insist on the first course. Given the will to provide good maternity care to every mother, the ways and means will be found.

What we want for every woman is easily stated: Medical care by a well-trained physician, starting, if possible, before conception or at least not later than the second month of pregnancy and given continuously throughout pregnancy, labor, and the puerperium; medical care for the newborn infant by a physician trained in the care of children; specialized consultant service readily available as needed by mother or child; nursing care by competent public health and hospital nurses for the mother throughout the whole period of maternity and for the infant; hospital clinic or health center service for the prenatal and postpartum periods for all maternity patients who seek this type of care; delivery care and at least ten days postpartum care in a hospital with all possible safeguards for the health of the mother and newborn infant; facilities for boarding or convalescent care before or after delivery for those mothers whose physical condition or home situation require it; the direct service of trained nurse-midwives working under the direction of a physician to assist with normal cases where there is an inadequate number of physicians to give necessary care; counseling service by a medical social worker in hospital and clinic to assure the provision of adequate food, shelter, clothing, and personal and family adjustment to the condition of maternity.

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* By Dr. Martha M. Eliot, Assistant Chief, U. S. Children's Bureau.

For editorial comment on maternity-pediatric care, see in this issue, on page 105.

There would seem to be little reason why decisions should not be reached now as to the general framework and many of the details of a plan for public maternity care and medical care of children to be put into effect after the war. At best it will take ten years to develop the program in all its parts. Today there is enough experience in this country and abroad to warrant laying down basic principles and a pattern of general procedure, but that pattern must be flexible enough to allow for variations in the different States and in urban and rural areas.

A review of this experience leads me to believe that the basic principles upon which we should proceed would be, in general, as follows:

1. Any public program of maternity care and medical care of infants and children should be the joint responsibility of local, State, and Federal governments financed under the grant-in-aid plan from general tax funds;

2. Administrative responsibility should rest with the State departments of health with expenditure of Federal funds under plans approved by the Federal agency given responsibility for the grants;

3. The program should be State-wide in effect and be so organized as to include a network of maternity and pediatric services that will reach out from a few highly organized maternity and pediatric units in hospital and teaching centers to a chain of smaller hospitals and clinics located strategically in medium sized cities and thence to the many small local maternity and child health units in towns and counties and rural areas;

4. Maternity care of good quality should be avaliable under this program to any woman who seeks it regardless of residence, economic status, race, color or creed; eligibility should be on the basis of medical need alone; this is surely one aspect of our total medical care program for which there should be no means test;

5. Standards of care should be established by the responsible administrative agencies with the advice of experts in the various professional and technical fields;

6. Employment practices in the case of professional personnel should be determined, first, by the required standards of care and, second, by economy in the expenditure of public funds;

7. Hospital and clinic facilities meeting established standards of maternity and infant care and care of sick children should be available or easily accessible to every community, rural as well as urban; public institutions should be open to everyone in the community whether the community or the individual pays; existing voluntary, nonprofit institutions, if used, should meet established standards of financial accounting as well as professional service;

8. The plan for training professional and technical personnel should be a part of the plan for service and reach down from the most highly organized teaching unit to the smallest rural unit.—From *Briefs*, Vol. VII, No. 6, June, 1943. Published by the Maternity Center Association, 654 Madison Avenue, New York 21, N. Y.

What an exciting super-tomorrow it will be! Americans are today making the greatest scientific developments in our history. That is a promise of new levels of employment, industrial activity and human happiness.

—Clarence Francis.

COMMITTEE ON MEDICAL ECONOMICS

Fee Schedule of California Industrial Accident Commission

A "proposed" fee schedule for physicians and surgeons to cover services rendered under the Workmen's Compensation and Safety Laws was presented to the Industrial Accident Commission of the State of California by the California Medical Association on December 30, 1942.

The matter is still under consideration by the Commission. A copy of the proposed fee table was sent to all physicians licensed to practice in California. Below are given the covering letters which were mailed with the proposed schedule.

* * *

(COPY)

California Medical Association
Four Fifty Sutter, San Francisco

To the Doctors of Medicine of California:

Dear Doctors:

The California Medical Association, representing more than 7,300 Doctors of Medicine in California, has been trying since late last year to have a new fee schedule adopted by the Industrial Accident Commission of the State of California for compensation work.

Enclosed, for your information, is a copy of the fee schedule proposed by the California Medical Association, compared with the fees now in effect with the Industrial Accident Commission. The present fees were approved by the Commission in 1920 and have remained unchanged for more than twenty-three years. As you will readily see, the present fee schedule is not only inadequate but is most incomplete. The proposed fees have been drawn up by a group of qualified physicians as representative of fair and adequate fees for compensation cases.

To date the Industrial Accident Commission has not approved the proposed fee schedule. However, the Commission has indicated that it will give serious consideration to the proposed schedule *if* ways and means can be found to secure the adherence of the physicians of California to the established fee schedule.

In other words, the physicians of California are in a position to secure more adequate fees for compensation work if they themselves will agree to stop the fee-splitting, rebating and discounting of compensation medical and surgical fees which some practitioners are alleged to be carrying on now.

Won't you add your name to the list of physicians who have already agreed to abide by the established fee schedule for compensation? The more agreements of this kind we can get, the better evidence of good faith we will have with the Industrial Accident Commission.

To be included in this form of agreement with all the other Doctors of Medicine of California, just sign the enclosed card and drop it in the mail today. No postage required—just your signature and city. With your help we can all hope for fair and adequate compensation medical and surgical fees.

Fraternally yours,
(Signed) Karl L. Schaupp, M. D.
President.

* * *

I agree that in compensation cases I will abide strictly by the fee schedule established by the Industrial Accident Commission of the State of California and will adhere to the Principles of Ethics governing compensation practice.

Signed..

City..

Outline of Procedure for Physicians When Claiming Fees Before the Industrial Accident Commission

In any case where a physician is dissatisfied with the fee proposed to be paid by the employer or insurance carrier in any workmen's compensation case, he may file an application with the Industrial Accident Commission for an adjustment of the matter of his fee in the following manner:

1. He should obtain from the Industrial Accident Commission its "Form 34 Revised," entitled "Application for Adjustment of Claim." The Commission has an office in San Francisco in Room 119, State Building, and in Los Angeles in the State Building.

2. The physician should ascertain from the Commission or the injured employee whether the employee has already filed an application with the Commission for an adjustment of his case and, if so, request the file number thereof.

3. The physician should fill in all the information requested on the above-mentioned form. If the employee has already filed his own application, the number of his claim and the title of the claim should be filled in on the form, adding the physician's name as an additional "applicant." If no previous application has been filed by the employee, the physician should fill in his own name as applicant *and also insert the employee's name in the title.* Question 8 on said form should be answered as follows:

> "The reasonable value of the medical services rendered to the injured employee by the undersigned applicant physician is the sum of..Dollars. A detailed statement of the services rendered the employee by the undersigned applicant is attached hereto. The above named employer and employer's insurance carrier have refused to pay compensation for said medical services in said sum (or have refused to pay in excess of.....................
> ....Dollars for said services). The undersigned applicant physician requests the Commission to award the sum of..Dollars to the employee as the reasonable expense incurred by said employee for medical services and further requests that the applicant physician's claim for medical services rendered, be declared a lien on said sum and that the employer or the insurance carrier be ordered to pay said sum directly to said physician."

The detailed statement of the medical services rendered to the employees should be attached to the application in accordance with the foregoing statement.

4. This application should be filed with the Industrial Accident Commission at either its San Francisco or Los Angeles office within six (6) months after the last treatment by the physician for the injury involved.

Cut in Insurance Rates Is Expected by State Official

State Insurance Commissioner A. Caminetti, Jr., said today reductions averaging 15 to 20 per cent in workmen's compensation insurance rates are expected to result from an investigation by his department into "questionable underwriting practices" in California.

He explained in a report to Governor Earl Warren that the state-wide investigation results from a preliminary probe revealed that special treatment either was obtained or given to employers through improper classification of risks, inaccurate reporting and auditing of pay rolls and various other devices.

Thorough Probe Agreed On

"Since any widespread practice along these lines must have the effect of distorting the data on the basis of which rates are fixed and premiums collected," he said, "it was deemed essential that a thorough investigation be made. When the existing condition is cleaned up, it should result in an average reduction of from 15 to 20 per cent in rates."

The investigation so far, he declared, has disclosed "an alarming prevalence" of discriminating practices and violation of the laws with respect to the giving of rebates. Some of the methods employed, he said, were so transparent they can be described only as wilful violations.

Evasion Methods Listed

He listed as some of the most common means employed in the evasion of proper ratings:

1. Concealment of pay rolls.
2. Misclassification of risks.
3. Acceptance by compensation insurance carriers of the assured's pay-roll statements without verification.
4. Agreements to write compensation in conjunction with other lines of insurance not subject to minimum rating laws.
5. Substitution of fictitious loss reports for reports of actual loss.
6. *Discounting physicians' bills while nevertheless reporting the gross amount for rating and experience purposes.*

Extent Undetermined

"The extent of the inaccuracies and misclassifications presently existing cannot at this stage be accurately gauged," Caminetti said, "but it is significant that in 132 audits completed involving pay rolls reported at $66,500,000, additional unreported pay rolls of $3,200,000 were disclosed. The investigation audits developed required premiums of $1,908,000 as against $1,551,000 reported."

It is to be hoped, he added, that the investigation may result in an eradication of "these destructive practices" and the laying of a sure foundation for rate making in workmen's compensation insurance.—Sacramento *Bee,* June 30.

Insurance Indemnification

The following letter was recently sent to the component county societies of the California Medical Association:

(COPY)

June 24, 1943.

Dear Doctors:

In the past few years the California Medical Association office has received an increasing number of inquiries from physicians as to the best method of handling their fees in cases where the patient carries indemnification insurance but where the indemnification might not represent the full fee which the physician believes to be proper.

For instance, a patient may have an indemnification insurance policy which allows him $50 for a hernia operation. The physician's fee might be set at $100, but the patient hopes to be relieved of any additional payment. The insurance carrier, upon receipt of proof of the surgery, may send to the physician its check for $50, the check being imprinted with some such statement as "In full payment for professional services rendered to John Doe."

If the physician accepts this check as part payment of his full fee, he is defeating his case for collection of the full fee. The physician has no contractual or other relationship with the indemnity insurance company. Such company's contract is with the patient.

The California Medical Association Council at its meeting of June 19 to 20, 1943, voted to forward to its members, through their county societies, the following instructions in such cases:

Do not accept checks from insurance companies for fees of patients carrying medical or surgical indemnification policies. You are under no contractual obligations to the insurance carrier, but are dealing directly and only with the patient under the usual physician-patient relationship.

Return such checks to the insurance company, together with a simple statement to the effect that you are handling *the matter of your fee direct with the patient. If the insurance company wishes to send its indemnification check to the patient, that is a matter between the company and its policyholder.*

Please bear in mind that these instructions apply only in cases of commercial insurance companies, employee benefit organizations, etc. *They are not applicable in the case of patients under California Physicians' Service memberships or in the case of patients covered by compensation insurance.*

The strict adherence of your members to these instructions will help greatly in combating the tendency of many commercial insurance companies to establish a schedule of medical and surgical fees which is too low and in no way representative of the fair value of the services.

Please give these instructions the widest possible publicity among your members.

Fraternally yours,
PHILIP K. GILMAN,
Chairman of the Council.

Prepaid Medical Plan Under Doctors' Study

A new medical organization to develop prepaid, group medical care throughout the nation met in Chicago on June 6 with the American Medical Association.

The group is the Medical Service Plans Council of America, organized four months ago, with 129 nonprofit, prepayment plans in actual operation in thirty-five states and Canada, covering about 13,000,000 persons.

Dr. James C. McCann, Worcester, Massachusetts, is president of the new council, and Dr. Frank L. Feierabend, Kansas City, is secretary-treasurer.

There are two classes of prepayment groups. Seventy-seven are group hospital associations and fifty-two are limited to surgery, births, and catastrophes like major accidents. Only these two classes, both of limited service, have succeeded well. Complete prepaid medical care is also being tried, but in the main costs too much.

The trustees of the American Medical Association summarized the difficulties in a report to guide physicians.

It said that the original complete medical service plans are being changed to limited surgical and obstetric care for hospitalized patients.

"It early became evident," said this report, "that an unlimited medical care plan involved a greater expense than can be met by any premiums the public is at present willing to pay."

Further, the report declared that the public "has been deceived as to cost by the propaganda for compulsory sickness insurance and for lay-administered plans."

The trustees' report sets up the principles that the medical care plans must never deceive the public, that there must be free choice of doctors, and no change in the personal relation between doctor and patient.—Los Angeles *Times*, June 7.

A "New Order" for the United States?

GOP Governor: "The Washington Mighty Want It"

Governor Edward Martin of Pennsylvania . . . in an address prepared for Flag day exercises in Independence Hall, declared that the report of the National Resources Planning Board is "the Holy Book of the new American order," and said it proposes "the system whereby our economic Fascists hope to control every step taken by Americans from their cradles to their graves."

Describing the Planning Board report, which proposed a social insurance to assure all Americans of lifelong freedom from want, Martin said:

"Its purpose is to end the incentive system and discourage or destroy the American initiative that . . . made this the freest and strongest nation in the world.

"It promises to set up a caste and class system whereby the young men and women of America will be frozen into a politico-economic system. It will sound the death knell to ambition.

"This great conflict of ideas is world-wide and is being fought in America under the smoke screen of war."—San Francisco *Chronicle*, June 15.

From Washington: Postwar Problems in Medical Service

Scores of doctors have asked Washington for enlightenment concerning the growing prospect they may be kept in uniform for years to staff veterans' hospitals. Officials cannot vouchsafe details on the postwar program but it is evident many medicos must be held over.

An eventual army-navy establishment of 10,000,000 men, possibly more, will mean heavy casualties from battle, disease and exposure. If the disabled total only 5 per cent—a conservative estimate—there will be 500,000 patients requiring attention, of whom large numbers will be chronic cases. Present plans contemplate an enormous extension of the physical plant, necessitating a tremendous personnel.

It is probable physicians will be asked to remain "voluntarily," but if the response does not produce an adequate force they will be obliged to forego a return to private practice.

Their possible retention in the armed services raises immediate personal problems. Many have invested thousands of dollars in office equipment which may deteriorate or become obsolete before the date of discharge. They must decide whether they should dispose of apparatus now or continue to pay insurance and storage costs.

A shortage of doctors for civilians after the peace may lead to a nationwide, federally operated medical service with wartime units as a center.—Sacramento *Bee*, June 10.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Doctor Shortage in East Bay Hospitals: San Francisco Bay Area

(Copy of Joint Report to Alameda County Medical Association and East Bay Hospital Conference.)

Four meetings have been held of the Liaison Committee, composed of representatives of the Alameda County Medical Association and representatives of the East Bay Hospital Conference, to discuss the shortage of hospital beds for private patients in the East Bay area.

The Alameda County Medical Association was represented by Dr. Clarence A. DePuy (chairman), Dr. R. T. Sutherland, and Dr. S. A. Jelte. The East Bay Hospital Conference was represented by Alfred E. Maffly of Berkeley Hospital (chairman), J. S. Rafter of Richmond Hospital, and Miss Ruth Wescott of Alameda Hospital. Others invited to attend the meetings were: Dr. Clifford Mack, president of the Alameda County Medical Association; G. U. Wood of Peralta Hospital, Miss Rainbow of the Visiting Nurse Association, Keith Taylor of Children's Hospital, and Doctor Blankenship of the U. S. Public Health Service.

Discussion

The main topic of the discussions was the shortage of hospital beds in the East Bay area. The medical profession and the hospitals of this area are both severely criticized by the public every time a patient is denied hospital facilities. For each patient rejected there is increasing pressure placed upon the Alameda County Hospital to open up its one hundred additional beds, and the Kaiser Group is further fortified in its demands for additional hospital facilities for 266 more bed patients. Neither physicians nor hospitals desire to see pay hospital patients accepted by the County Hospital nor further expansion of the corporate practice of medicine.

Discussion revealed that patients were being rejected by East Bay hospitals, not merely because of shortage of hospital beds and hospital facilities, but primarily because of the shortage of nurses and trained hospital personnel. Most of the hospitals have been increasing their capacities by purchasing additional beds and additional bedside equipment and doubling up their present facilities. There has been no particular difficulty experienced in purchasing hospital equipment of this type. The main problem has constantly been the increasing shortage of hospital man power. Hospitals have frequently been obliged to cancel surgery and to reject bed patients, even though they had unfilled beds available, because of inadequate nursing care for the facilities which they did have. Purchase of additional beds alone will solve little.

Spot Check on Hospital Facilities

The Committee made several spot checks of hospital facilities and hospital occupancy. The following is a typical study taken of the nine approved hospitals at midnight on May 10, 1943. The census figures were taken at midnight, as this is the usual customary time of computation.

OCCUPANCY STATISTICS

Approved Private Hospitals in East Bay May 29, 1943

11:59 p. m. (Midnight)

Hospital	Total Capacity	Empty Adult Beds	Rejected Patients 5/21-5/27	Per Cent Occupancy
Alameda	97	21	8	
Alta Bates	116	14	0	
Berkeley	90	23	0	
Children's	70	12	0	
East Oakland	80	12	1	
Merritt	178	11	(No pvt. rm.) 42	
Peralta	160	14	12	
Providence	220	28	6	
Richmond	61	9	0	
	1,072	144	69	77

Of 1,072 hospital beds now available for private patients (not including bassinets for newborn), 144 were empty at midnight of May 29. However, while it was true that many of these empty beds were filled the following noon and certain hospitals were completely filled to capacity by then, other hospitals were not overloaded and could have taken care of patients rejected.

Under present conditions several hospitals are reserving their beds primarily for the use of their active staff. In fact, some of the hospitals have made their beds available to their active staff *exclusively*, even though there were empty beds which might have been used by courtesy staff members.

Conclusions and Recommendations

The Committee wishes to express the following conclusions and recommendations:

1. *There is no overwhelming shortage of hospital facilities in the East Bay.* Present facilities are cramped and are being used to capacity, but should be adequate to take care of the acutely ill and severely injured. If our hospital facilities are used to maximum capacity, all luxury hospitalization abolished, all patients discharged from the hospital at the earliest possible time, and with complete coöperation of the doctors and hospitals, it should rarely be necessary to reject critically ill private patients.

2. *Further reduction in the average hospital stay of patients.* Obstetrical cases have already been reduced from ten days to five days in most hospitals. Surgical and medical patient stays should similarly be reduced to 50 per cent if possible. The hospital stay of industrial cases should be greatly reduced.

3. *Orthopedic and other convalescent patients* should be sent home or transferred to convalescent homes as quickly as possible. A list of convalescent homes should be prepared for the Central Clearing Agency.

4. *Facilities for the rental of bedside equipment* should be investigated so that more hospital facilities might be made available to encourage some of the less acutely ill patients to set up their own hospital facilities at home.

5. Arrangements might be made with the *Visiting Nurse Association* for more bedside care at home.

6. *Luxury nursing and luxury hospital service should be abolished for the duration.* Hospital and nursing care should be requested on the basis of medical need only, not merely because of the financial ability to pay.

7. *Special duty nursing should be minimized* to assure more efficient distribution of the available nursing care. Special nursing should be limited to the extremely sick and for medical reasons only. Special nurses should care for two or three or even four patients at one time.

8. *Registered nurses* now employed in doctors' offices should be encouraged to accept general staff duty, and doctors encouraged to employ competent medical secretaries rather than registered nurses wherever possible.

9. *Retired and inactive nurses* should be encouraged to enroll in refresher courses and return to the field of general duty nursing either on a full time or a part time basis as part of the Victory Nurse Program.

10. *Hospitals should make full use of volunteers. Red Cross nurses aides* should be used more extensively in hospitals to relieve nurses. Doctor Sutherland investigated the availability of volunteer help for the Committee and found that hospitals had not used volunteers to maximum capacity in their various departments. By July 31, 1943, 743 nurses' aides will have been graduated by the Red Cross in Oakland and Berkeley. Each hospital should set up a weekly program stating the number of aides desired, preferably by regular four-hour periods each week. The Red Cross already has many more nurses' aides available than the hospitals have been willing to absorb. When sent to the hospital, the aides should be used for real work and not just tolerated.

11. Hospitals should take advantage of *Victory Worker Campaigns* being conducted by local manpower committees. Many victory workers are available for work in hospital and other essential industries after they have completed their regular day's work of eight hours in other occupations. Victory workers are available for four-hour or other part-time shifts. Many housewives are available for such part-time work in hospitals after completing their home tasks each day.

12. *Hospital staffs should not hoard beds for their active staff members.* Empty beds should be made available to all members of the Alameda County Medical Association for the duration. Doctors should become active staff members in more than one hospital so that they will have more hospital beds available for their practice.

13. *If the present pressure for hospital facilities becomes more acute, it is recommended that a central clearing agency might be set up for more effectual use of vacant beds.* The Alameda County Medical Association or the East Bay Hospital Conference could maintain such a clearing house in their secretaries' office. One clerk could be detailed to telephone each of the nine hospitals every morning to determine the number of empty beds available. When a physician could not be accommodated by the hospital of which he is an active staff member, he could be aided by the central clearing agency, which might be able to assist him to procure accommodations in another hospital which happened to have vacant beds at that time. This plan would require the coöperation of all hospital staffs and their willingness to make their empty beds available to all members of the Alameda County Medical Association.

In Conclusion

In conclusion, your Committee is convinced that present hospital facilities in this area should be adequate to take care of those urgently needing hospital care, provided doctor, hospital, and patients are willing to coöperate for the duration in eliminating luxury services, and willing to ration hospital facilities for the benefit of the severely ill in the most efficient manner.

June 15, 1943.

Respectfully submitted,
Clarence A. DePuy, M.D.,
Medical Chairman.
Alfred E. Maffly,
Hospital Chairman.

Medical Staffs Give $101,250 to Hospital Fund

Medical staffs of eight Los Angeles nonprofit hospitals—the doctors who best know the immediate need for 800 beds and other facilities—have contributed $101,250 to the United Hospital Fund $3,000,000 campaign.

Dr. L. A. Alesen, secretary of the Los Angeles County Medical Association, announced the staff gifts yesterday.

Physicians and surgeons are giving generously, Doctor Alesen said, because they know the danger confronting the public when hospitals are unable to care for all the patients.

"They realize that an average of more than one thousand persons a month are being turned away by these hospitals," he explained, "while many hundreds of patients are discharged earlier than is desirable in order to make room for new patients."—Los Angeles *Times*, July 14.

County Auditor Hits Hospitals' Billing Method

The method known as "selective billing" of patients treated at the Los Angeles County General Hospital and kindred institutions operated by the county government was criticized in a report by County Auditor J. M. Lowery to the Board of Supervisors.

Selective billing permits segregation of patients, those who might pay for their hospitalization from those unlikely to pay.

According to the Auditor the county is losing revenue because of the selective billing system and he recommended that it be discontinued for the General Hospital. . . .

Arthur J. Will, Director of County Institutions, in a communication to the Board, favors the selective billing system. He says:

"To review periodically all past cases of General Hospital patients and seek reimbursement from all who have not paid would require a staff of five hundred persons.—Los Angeles *Times*, June 14.

"Twenty-Five Years Ago"—The Way Things Change

The following news item refers to comment which appeared in the "Twenty-Five Years Ago" department of California and Western Medicine:

> California and Western Medicine, the official journal of the California Medical Association, has a feature called "Twenty-Five Years Ago," in which are reproduced interesting items which appeared in the magazine a quarter of a century ago. In a recent issue of the magazine, one of the items reprinted concerned the Navy's call for binoculars, spyglasses and telescopes in 1918. The writer of the story stated that an appeal in the daily press had resulted in the receipt of more than 3,000 glasses. "This number, however," he said, "is wholly insufficient, and the Navy needs many thousands more." And we add his next paragraph in full, just to show you what some people were occupied with a quarter of a century ago. "All articles should be securely tagged, giving the name and address of the donor, and forwarded by mail or express to the Honorable Frankiin D. Roosevelt, Assistant Secretary of the Navy, care of Naval Observatory, Washington, D. C., so that they may be acknowledged hy him."—San Francisco *Chronicle*, June 2.

COUNTY SOCIETIES[†]

CHANGES IN MEMBERSHIP

New Members (44)

Alameda County (2)

Barron, Gilbert, *Oakland*
Ellis, John Malcolm, *Berkeley*

Fresno County (1)

Hagen, Kathryn L., *Fresno*

Imperial County (2)

Gregory, Benjamin F., *Brawley*
Yellen, Benjamin L., *Brawley*

Kern County (2)

Seibly, John, *Bakersfield*
Wynia, Frederick, *Bakersfield*

Los Angeles County (18)

Borsook, M. E., *Los Angeles*
Chaney, O. J., *Inglewood*
Cummings, Arthur L., *Burbank*
Eames, Earl, *Roscoe*
Freed, Arnold Lawrence, *Los Angeles*
Jameson, Moroni, *Long Beach*
Jones, Wilfred M. G., *Los Angeles*
Kelly, Edward H., *Monrovia*
Knouf, Evelynne G., *San Marino*
Lee, Harold I., *Duarte*
Lynn, Isaac W., *Burbank*
Naiditch, Morris J., *Los Angeles*
Neufeld, Otto J., *Los Angeles*
Potter, Glenn James, *Los Angeles*
Shayne, David M., *Los Angeles*
Stewart, Robert B., *Los Angeles*
Stricker, Robert L., *Los Angeles*
Woodruff, James Lloyd, *Los Angeles*

Monterey County (1)

Whiffen, Robert A., *Salinas*

Orange County (4)

Anderson, Ralph D., *Orange*
Artress, F. Lynn, *Fullerton*
Koch, George W., *Anaheim*
Schroeder, Alfred L., *Orange*

Riverside County (1)

O'Connell, Raymond, *Indio*

Sacramento County (2)

Bockrath, Henry M., *Sacramento*
Ogaard, Adolph T., *New Orleans, Louisiana*

San Diego County (1)

Oliphant, Charles L., *Topeka, Kansas*

San Luis Obispo County (1)

Pearman, Robert O., *San Luis Obispo*

Santa Barbara County (1)

Dixon, J. Lowell, *Santa Barbara*

Santa Clara County (4)

Brundage, Burchard M., *San Jose*
Hardenbergh, Helen, *San Jose*
Robertson, Gaynelle, *Palo Alto*
Watson, Robert W., *San Jose*

Santa Cruz County (1)

Holleman, Clarence H., *Santa Cruz*

Stanislaus County (2)

Semmens, D. W., *Modesto*
Treadwell, Richard R., *Modesto*

Yuba-Sutter-Colusa County (1)

Clemens, H. H., *Morganville*

[†] For roster of officers of component county medical societies, see page 4 in front advertising section.

Transfers (3)

Frank, Justin A., from Santa Barbara County to Los Angeles County

Obrien, George F., from Solano County to Sacramento County

Wood, Howard Asa, from Riverside County to Los Angeles County

Retired Members (1)

Coffey, Walter B., *San Francisco*

In Memoriam

Altman, Allen Ashton. (Lieutenant, MC, USA). Died at Adak, Alaska, April 11, 1943, age 29. Graduate of Stanford University School of Medicine, 1939. Licensed in California in 1939. Doctor Altman was a member of the San Francisco County Medical Society and the California Medical Association.

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Augspurger, Elmer David. Died at San Francisco, June 25, 1943, age 63. Graduate of the University of Illinois College of Medicine, Chicago, 1907. Licensed in California in 1915. Doctor Augspurger was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Beach, Everett Charles. Died at Oxnard, July 8, 1943, age 63. Graduate of the Baltimore Medical College, Maryland, 1907. Licensed in California in 1908. Doctor Beach was a member of the Ventura County Medical Society and the California Medical Association.

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McManus, Edward Austin. Died at Los Angeles, June 9, 1943, age 53. Graduate of the Royal College of Physicians of Ireland, 1923. Licensed in California in 1938. Doctor McManus was a member of the Los Angeles County Medical Association and the California Medical Association.

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Rapaport, Hyman. Died at Los Angeles, June 16, 1943, age 51. Graduate of the University of Pittsburgh School of Medicine, Pennsylvania, 1919. Licensed in California in 1920. Doctor Rapaport was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Walker, Clifford Black. Died at Los Angeles, July 3, 1943, age 58. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1911. Licensed in California in 1924. Doctor Walker was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Wolfsohn, Julian Mast. Died at San Francisco, July 1, 1943, age 60. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1911. Licensed in California in 1911. Doctor Wolfsohn was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Zeiler, Avrum Herman. Died at Los Angeles, July 16, 1943, age 61. Graduate of Columbia University College of Physicians and Surgeons, New York City, 1905. Licensed in California in 1912. Doctor Zeiler was a member of the Los Angelcs County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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OBITUARIES

A. H. Zeiler
1882–1943

We have lost a friend, and such a friend! Herman Zeiler was the doctor's doctor, ready day or night, though sometimes sick himself, to lend aid whenever a colleague asked assistance. And the calls were frequent, for Zeiler participated in the inauguration of clinical laboratories at six Los Angeles hospitals and supervised the work of a capable staff. Besides institutional commitments, he shared heavily the responsibility in a group conducting an active private laboratory that served physicians individually. In this capacity, alert to the steady progress of medical science, he was able to shorten the lag between the publication of significant discoveries and their wide application to the practice of medicine. He earned the gratitude of fellow physicians, along with the manifold blessings of their patients.

Born in Sombor, Austria (Hungary), Herman came with his parents to America when five years old. The family settled in Leadville, Colorado. His medical education began at the College of Physicians and Surgeons, New York, affiliated with Columbia University. He was graduated in 1905. His training was continued at Bellevue Hospital, at municipal institutions on Blackwell's Island, and culminated while in the service of his country under the command of General Gorgas in the Panama Canal Zone.

In other ways, pivotal indeed, residence in the tropics was kindly and brought fair rewards. There he met Miss Geneva Dunkl, whom later he married. Two children were born to them, a son and a daughter. Also, he became acquainted there with Dr. Walter Brem and a relationship began which flourished, inspiring them to move to Los Angeles in 1911 with a plan for establishing jointly a pathological laboratory comparable with those in the Government hospitals at Ancon and Colon, where they had worked side by side.

The venture at first had limited objectives, aspiring chiefly to interpret the lesions in tissues removed at operation, thus to guide the subsequent welfare of the patient.

Pertinent, of course, was the blood picture before and after operation. Again, in other instances, medical cases, repeated differential counts were required to learn the effect of treatment upon profound anemia or leukemia. These events merit emphasis because they pointed the notable expansion about to occur in the laboratory and give it prominence for pioneering blood transfusions as well as intravenous therapy of different kinds. Step by step, equipment was acquired for microchemical study of the blood, intricate procedures of urinalysis, refined bacteriological technique, metabolic research, and various innovations in the field of pathological physiology during the past three decades. Enumeration of these details is more convincing than mere statement of the fact that Zeiler had an open mind, quick to avail himself of the truths science discloses for the benefit of sick men and women.

For him Medicine was both vocation and avocation. Leisure was found to contribute toward the activities of the County Medical Association: Membership on committees, the furtherance of lay knowledge relative to the rôle of doctors in the solution of community problems, the advancement of the peculiar interests of the Society, scientific and financial. In this regard one illustration is afforded by the energy he expended in bringing to accomplishment the project of the Wilshire Medical Building, which through the lease of land by the Association supplies resources to multiply our library facilities and makes the future of the Association exceptionally secure.

Personal appreciation of Herman Zeiler by his colleagues was always prompt and genuine. Honest to the core and with no veneer to obscure the man's straightforward purpose, work was the pith of his philosophy. Never did he spare himself, despite intermittent attacks of illness covering nearly a score of years. Persistently outgiving, faithful to any responsibility he assumed, critical of himself but not of his associates, modest, understanding, upright, loyal—he made a host of friends and kept them.

A Tribute From an Old Friend.

✠

Clifford B. Walker
1884–1943

The world of science lost one of its most brilliant and shining stars when Dr. Clifford B. Walker of Los Angeles died on July 3, 1943. Doctor Walker was born in Vermont, acquired part of his education in Pasadena, received his B. S. in 1906 from the University of California, and was graduated from Johns Hopkins Medical School in 1911, already with a proved talent for research. In 1913, at the opening of the Peter Bent Brigham Hospital in Boston, he was selected as one of that remarkable group of young men of genius and talent which Dr. Harvey Cushing gathered about him, dedicated to the study of the nervous system as a surgical field of promise and hope.

Doctor Walker was not only a man of talent, but definitely in the genius class. His special bent for physics and mathematics made it natural for him to do his research in the abstruse realms of optics and the physics and physiology of the eye.

It was this genius, plus unrelenting study and intensive research, which blossomed into the many contributions he gave to the world, such as his operative procedure for detachment of the retina, and the "Walker" screen for visual fields. Doctor Walker's knowledge of quantitative perimetry became so outstanding that it received merited recognition throughout the scientific world, a recognition signalized by the award to him of the rare and coveted Knapp Memorial Prize, given only for the highest achievements in ophthalmology.

Doctor Walker was a man of great talents, a physician who did much pioneer work in a difficult field of science. It will not be an easy task to find his equal.

George P. Laton, M. D.

✠

Dorsey A. Harwood
1879–1943

This is a tribute to the memory of a fine, courtly gentleman; to a man whose cultural and professional attainments placed him upon a conspicuous pedestal of professional esteem and popularity in Santa Ana, in Orange County, and throughout the State of California.

Dorsey A. Harwood was born in Manville, Illinois, on December 5, 1879. He chose the profession of medicine as his life's vocation and was graduated from the University of Illinois in 1906. He served his interneship in St. Luke's Hospital and practiced at Ransom and Streator in Illinois until 1920, when he made his way to California and settled in Santa Ana. There he acquired a well-deserved and enviable reputation as a surgeon, paying particular attention to malignant diseases.

To all appearances, Doctor Harwood enjoyed excellent health, but he, himself, was aware of a serious heart condition. Nevertheless, he continued to work until within two days of his untimely death.

Doctor Harwood was a representative of a rare type: sound in logic, keen in judgment, strong in his convictions and often apparently abrupt, yet kindly and lovable.

Doctor Harwood's death is a severe loss to the Orange County Medical Society, of which he was president for the current year. This is a brief and inadequate summary of the life of a man who was a credit and an honor to the medical profession, and whose days were filled with kind deeds and splendid achievements. C. C. V.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION[†]

MRS. CHARLES C. LANDIS............President
MRS. ROGER McKENZIE............Chairman of Publicity

Pending readjustment in the duties of officers of the California Medical Association Woman's Auxiliary, space allotted to this department is allocated this month to a report on the Cancer Control Educational Program of the Women's Field Army of the "American Society for the Control of Cancer." Report follows.

The Cancer Control Educational Program for 1943. At this time we purposely leave the clinical or medical phase of the educational work to the trained physician, where it rightfully belongs.

The educational progress in cancer control is basically one of personal contact and personal participation.

Clarence Cook Little, D. Sc., managing director of the American Society for the Control of Cancer, Inc., announces in making an analytic study looking toward a secondary school cancer-control study program: "It is increasingly clear that the time is ripe for an intensive drive to bring the secondary schools into our program. The advantage of such participation by young people is evident. If they are trained to be interested and active in cancer control before cancer becomes a personal problem, their attitude as adults will be more rational, more constructive, and less one of uncontrolled emotion."

[†] Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Roger McKenzie, 138 Twenty-fifth Avenue, San Francisco. For roster of state and county officers, see page 6, in front advertising section.

We have undertaken in California this year a vigorous expansion of the educational program to try to reach the young adult public. We have contacted each of the 450 high schools in the State and suggested that through the science, biology, or health courses that accurate general information be obtained from representatives of the American Society for the Control of Cancer in their community and that this material be used in classroom discussion. There are many easily understood pamphlets carefully written for the public that high school students can understand. There are two excellent sound films, entitled "Choose to Live" and "Enemy X," which will be shown in many general assemblies throughout the State.

A 500-word essay contest is being sponsored among California high school students on the subject, "Fight Cancer With Knowledge." An award of a $25 war bond is being offered for the best essay submitted, governed by the decision of three judges.

Over one hundred junior colleges, colleges, and universities in California are being stimulated as to obtain scientific material in the form of pamphlets, books, and films. It is extremely important that every young adult be made aware of the nature of the disease, its first signs and symptoms, and the availability of reliable diagnosis and treatment.

Also, this year, the State Committee has prepared and issued a brief outline of instructions, in response to requests from the Red Cross chapters, on the care of cancer patients to be included in lectures to Volunteer Nurses' Aide Corps and Home Nursing Classes as a special part of the war-time service educational program. . . .

Knowledge is the one weapon with which we can fight cancer and expect to win. There is no need to withhold information about cancer, as it has been proved time and time again that accurate information in the minds of young and old alike gives rise to intelligent questions and understanding of the problems involved and destroys fear rather than creates it. Mysterious half-truths and exaggerated accounts give birth to misapprehension and false notions which do not help in conquering any major enemy.

We have emphasized the cancer control educational program and indicated to you the methods used. Through lectures, radio programs, literature, sound films, magazine and newspaper articles and editorials, and the 500-word essay contest in the high schools, we hope to bring into every home, scientific information that will unfold already proved knowledge available to every citizen. . . .

In the United States there are more than 376 clinics approved of by the American College of Surgeons, and in the State of California there are twenty-two approved clinics. Cancer preventive clinics have been established in many communities throughout the nation.

Let us all be as informed as the group of California high school students and vigorously carry out on the home front, with knowledge as our weapon, a fight against an enemy we can conquer.

Avail yourselves of pamphlets and other material being distributed by the California State Division of the Women's Field Army of the American Society for the Control of Cancer, Inc., from the State office, 3 West Carrillo Street, Santa Barbara, or your county division.

HELEN INGALLS ULLMAN,
State Commander.

DR. HELEN E. SWEET,
Educational Director.

CALIFORNIA PHYSICIANS' SERVICE[†]

Beneficiary Membership

Commercial (June, 1943)		46,350
Rural Health Program		5,000
War Housing Projects (approximate)		41,759
Marin	6,308	
Los Angeles	6,581	
San Diego	13,320	
Vallejo	14,750	
San Francisco	1,747	
Total		93,309

There has been a great deal of discussion lately about California Physicians' Service activities in collaboration with governmental agencies. A goodly segment of the medical profession has intimated that this is a very dangerous practice in that it is leading the medical profession into the hands of these agencies. Some of these persons also believe that California Physicians' Service, because of these activities, is leading the medical profession into state medicine. Some of the rumblings of the medical profession, which were evident at the recent meeting of the Medical Association at Los Angeles, and more recently at the special meeting of the Council of the California Medical Association to discuss California Physicians' Service activities, lead us to believe that this is one of the fundamental misconceptions on the part of those who have objections to California Physicians' Service. For this reason, it may be well for us to review some of the relationships the California Physicians' Service has had with the two governmental agencies with which they are now collaborating, namely, the Farm Security Administration and the Federal Public Housing Authority.

* * *

The *Farm Security Administration* was one of the first governmental agencies to enter the field of medical care on a large-scale basis. Today their program has developed to a point where it is probably the largest single medical care program in the United States. It is operating in practically every state in the Union. The policy of the Farm Security Administration has always been, before introducing its plan in any state, to first clear with the Medical Association of that state. After having obtained their endorsement, the Farm Security Administration then went out to deal with local county medical societies in areas where their program was to be put into effect. This has been the story of the Farm Security, and it has several thousand so-called "county units" now operating.

The Farm Security Administration was very anxious to come into California about the time that California Physicians' Service was organized. After the California Physicians' Service machinery was developed, the Farm Security Administration, which has quite a sizeable rehabilitation plan here, came to the California Medical Association with a proposal to introduce its program. It was only natural at that time that the matter be referred to California Physicians' Service. We entered into an experimental program with them in three areas in this State on a basis quite different from any other program they had operating in any other part of the nation. Whereas most other programs were very limited in nature and cost between $18 and $25 a year, California Physicians' Service was able to negotiate a contract with the Farm Security for more extensive service at a considerably increased rate—that is, approximately $50.

[†] Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

Because the experiment worked out quite successfully the first year, the Farm Security Administration desired to spread the program on a state-wide basis, and did so. As the program spread, it was evident to California Physicians' Service that a wide, diffuse program was a different venture than three small concentrated programs, and contained a good many administrative difficulties not common to the experience we had gone through in the previous year.

For this reason, the second year did not work out quite as well as the first and before going into the third year California Physicians' Service was able to sit down with the Farm Security Administration officials and renegotiate the contract on the basis of the experience so gathered. The contract that will go into effect at the end of this year is a clean-cut one; it has a lot of the objections to it removed, and is undoubtedly financially sound.

We mention this fact because it can be seen from here that a governmental agency is able to sit down with representatives of the medical profession and to discuss problems and to solve them by mutual agreement. It also shows the very desirable feature that the program is flexible and can be changed from time to time as all of us get more experience in unknown fields. The Government must necessarily enter this picture, because these farmers are the so-called "low income" farmers, and are borrowers from the Farm Security Administration, and in many cases are even given grants for medical care by that agency. The part played by the Government in the picture, then, is to arrange for the finances and to arrange for the enrollment of the prospective members. This reduces considerably the cost to the medical profession in reaching the group of people we are most anxious to care for.

* * *

This same type of arrangement has been used in relation to the *Federal Public Housing Authority*, wherein the medical needs of the disaster areas connected with war production had to be met. The procedure followed with the Farm Security Administration was followed in our negotiations with the Housing Authority. This program has been in effect only six months, and our figures have already shown that there are inherent weaknesses in the plan and that they must be rectified quickly.

Despite all the consulting with every known expert on the subject of medical care, the actuarial standing of the plan completely overrode any predictions. It is to be remembered that in arranging this plan we consulted with experts of the United States Public Health Service, whose job it has been for years to study the costs of medical care. This is the type of information that governmental agencies have been gathering in anticipation of the possibility of some national action. These figures are the ones that will be used in the compiling of any medical care of public nature.

Because we are dealing with a governmental agency on a contractual basis, California Physicians' Service, finding itself not discharging its responsibility to the medical profession as a whole in relation to fees for services, found it necessary to notify the Housing Authority that the contract would be terminated in sixty days unless certain readjustments could be made. These negotiations are under way at the present time—this time using the figures that California Physicians' Service has accumulated in actual experience while rendering care. Undoubtedly readjustments will be made in the form of reducing some of the benefits or increasing the cost. This flexibility is in startling contrast to fees that are fixed by legislation. We only have to mention the inflexibility of the Industrial Accident schedule.

In all of these negotiations the Housing Authority has shown great willingness to deal with California Physicians' Service, and is extremely interested in the experience that we have had. This is not only true of this agency as well as the Farm Security Administration, but all other parties who are interested in medical care. In all of our dealings with governmental agencies there has been a clear dividing line between the functions of the Government and the functions of the medical plan. The administration of the professional matters, relationship of doctors, hospitals, etc., has been completely in the hands of California Physicians' Service. There has never been at any time any interference on professional matters by the governmental agencies. They are only too glad to have this responsibility placed in the hands of those in whom they have confidence.

This is the first time in the history of the United States that information on a practical basis, rather than a theoretical basis, is being obtained. It is not unimaginable that this information will not be confined locally, but will gradually come to the hands of those who are really trying to find out costs, and the various problems that must be faced in instituting a widespread medical care program.

There is complete evidence, then, in the experience of California Physicians' Service in dealing with governmental agencies, that there is no intent on their part to interfere; as a matter of fact, there is a desire on their part to have the medical profession coöperate with them in endeavors in which they find medical care a necessary part of their programs. The only State in the Union where they can approach this subject on a state-wide basis is California.

* * *

(COPY)

(Copy of California Physicians' Service Report of July 22 to Professional Members)

CALIFORNIA PHYSICIANS' SERVICE
153 Kearny Street
San Francisco, California
743 South Grand View Street
Los Angeles, California

All of us realize that the key to successful operations is the coöperation of the medical profession. One of our problems has been the development of a method by which the medical profession can adequately be informed as to the various California Physicians' Service functions.

Our enrollment of beneficiary members has been mostly in the San Francisco and Los Angeles areas. During the past four years we have had numerous inquiries from county medical societies and from employed groups within these counties asking that our service be inaugurated. We have now developed a method of operation by counties which is in accord with the wishes of the county medical societies and the public. We are organizing these districts in the following manner:

Upon the approval and under the sponsorship of the county medical society, California Physicians' Service sets up a district office and places a district manager in charge. The only program presented to the employed groups whose family income is $3,000 a year or less is "Surgical and Hospital Care." Each doctor is contacted, the plan is thoroughly explained and his approval secured. The district manager reports his activities to the county medical society each month. Any differences or complaints from doctors or groups is given immediate attention by the district manager. Recommendations and suggestions from the county medical society are transmitted to the trustees of California Physicians' Service. This "district plan" is now operating in several counties, and to date the results have been most gratifying because this method tends to:

1. Keep the county societies informed as to our local as well as state-wide operations.

2. Afford county societies an organized means of expression regarding California Physicians' Service.

3. Advise the public that their local doctors are willing to help solve their medical problems.

Financial operations for the month of May are as follows:

Membership dues	$54,591.15
Professional member registration fee	45.00
	54,636.15
Administrative costs	10,420.12
	44,216.03
Hospital and laboratory	2,049.95
Available for medical service	42,166.08
20,730.8 units of service at $1.75	36,278.90
Transferred to Unit Stabilization Fund	5,887.18
Previous balance in Fund	30,507.13
Present balance in Unit Stabilization Fund	$36,394.31

Sincerely yours,

A. E. Larsen, M. D.,
Executive Medical Director.

Medical Dilemma in Housing Projects

California Physicians' Service to Quit Medical Centers on September 30

The California Physicians' Service is unable to continue treating sickness in the Federal housing projects in California.

So California Physicians' Service is quitting.

And the ills of tens of thousands of project tenants—800,000 in the Bay area alone—will become the responsibility of everybody else's family doctor.

The reason: California Physicians' Service is financially unable to continue its prepaid health program in housing projects.

That decision was reached after many weeks of conference by California Physicians' Service and all interested Federal agencies, which resulted in notice being sent to project managers that California Physicians' Service would withdraw its personnel and facilities on September 30.

For many weeks *The Chronicle,* through its page for war workers, *"Yanks on the Home Front,"* has been emphasizing the need for doctors and nurses in housing projects and citing the success California Physicians' Service has achieved in the projects it has served.

The California Physicians' Service decision means that twenty-two doctors and forty-nine nurses in projects at Marin City, Vallejo, Contra Costa, San Francisco, Los Angeles, and San Diego will pack up and leave in a month and a half. There was no California Physicians' Service system in projects other than those.

Heavy Losses

Without on-project medical centers, project tenants will be forced to seek medical attention from the already overworked doctors in near-by communities. There are fewer of those and many more patients.

California Physicians' Service has been losing heavily, according to Dr. A. E. Larsen, its director.

In May, for example, its income was $55,462, while its expenditures were $103,797—a 50 per cent loss. That month is typical, officials say.

Dozens of worried Federal officials and officers of medical associations are working on a plan to save California Physicians' Service centers in housing projects.

That plan, according to project executives, would include all tenants in all projects in California Physicians' Service prepaid health program and thus assure doctors and nurses for every tenant's needs.

So far, California Physicians' Service has extended its services to six California projects.

Cancellation Fear

Project executives are asking those tenants who are buying health protection from California Physicians' Service to continue making their monthly payments in the hope that the new plan will be approved by Federal Public Housing Authority officials in Washington.

California Physicians' Service doctors say that too few project tenants have volunteered to pay the monthly fee for health protection and that an enormous number of obstetrical cases has drained the California Physicians' Service treasury.

When the voluntary health insurance plan was worked out a year and a half ago, it was based on a birth rate of 17 births to each 1,000 individuals. In housing projects that ratio has zoomed to 100 births per 1,000 individuals.

Another factor in depleting the California Physicians' Service treasury, officials say, is the enormous number of workers, declared physically unfit by the military, who are now employed in shipyards and who need medical attention.

With 100 per cent enrollment, they say, all the needs of all the tenants can be met.

* * *

California Physicians' Service May Yet Be Saved!

Don't cancel your California Physicians' Service insurance! You may need medical attention between now and September 30.

That plea was directed to housing project tenants who are now benefiting from the California Physicians' Service prepaid health plan. (See accompanying story about the threatened dissolution of California Physicians' Service on project services.)

Don't cancel your California Physicians' Service insurance, housing officials say, because there is a chance the program may be saved.

To help save California Physicians' Service for housing project tenants, "Yanks on the Home Front" invites everyone who has benefited—and paid—for its services to write their experiences to *The Chronicle.*

Address your letter to "Yanks on the Home Front," *The Chronicle,* Fifth and Mission streets, San Francisco.—San Francisco *Chronicle,* August 13, 1943.

War Housing Projects Face Loss of Physicians' Service

Faced with mounting deficits in its housing fund, but still trying to find a way out "because the need is so evident and the medical profession recognizes it," the California Physicians' Service today was preparing to seek Federal assistance to continue its care of 60,000 persons in California housing projects.

"Unless we can make some adjustment, we will have to withdraw from our housing projects in Long Beach, Vallejo, Marin City, Richmond, and Hunters Point in San Francisco," Dr. Albert E. Larsen, medical director of California Physicians' Service, said today. "We already have withdrawn from the San Diego housing project, where the situation became financially impossible," he added.

Whatever decision is finally reached, with September 1 as the deadline, it will not affect the general operations of the California Physicians' Service, Doctor Larsen emphasized.

California Physicians' Service was organized independently under auspices of the California Medical Association. Physicians and surgeons of the Association contribute their services on a pro rata basis, getting only partial pay when funds are low.

"Except in San Diego, where some doctors withdrew because of a dispute over the organization, we haven't had a doctor quit," Doctor Larsen said, "and don't forget that the doctors are the ones who are getting nothing and still are standing by because the need is great and they recognize it."

California Physicians' Service has established medical care centers in the projects, and last winter proved its value when it had but one case of pneumonia.

Obstetrical expenses have been the heaviest drain in the housing project funds, Doctor Larsen said. He said that while the national birth rate average is 22 per 1,000 persons, in the housing centers it has been 100 per 1,000. Furthermore, he noted, housing project occupants have been selected on the basis of need, and many have required expensive treatments.

Doctor Larsen and Langdon Post, regional director of the Federal Public Housing Agency, will leave for Washington to confer on the problem with officials of the FPHA following a conference here August 22 with the Council of the California Medical Association. They will seek approval and assistance in raising the monthly rates for childless couples from $4 to $6 and for families of three or more from $5 to $7.50. The fee for single persons would remain at $2.50.—San Francisco *News*, August 13, 1943.

California Physicians' Service and Federal Housing Authority

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

July 30, 1943.

To the Secretaries of the County Medical Societies:

Dear Doctors:

I am sure that all the members of your society will be vitally interested in the developments of the past two weeks in the arrangements between California Physicians' Service and the Federal Public Housing Authority for the furnishing of medical care to the occupants of federal housing units in the war industry areas.

In brief, California Physicians' Service has notified the Federal Public Housing Authority that it is financially impossible to continue giving medical care on the basis of the present contract and that unless additional funds are forthcoming for the payment of standard units to the professional members of California Physicians' Service, the contract must be canceled.

This notification has been placed before the Federal Public Housing Authority on a basis of urgency, with the full knowledge on the part of all concerned that unless satisfactory financial arrangements can be made within the next sixty days, California Physicians' Service will withdraw from the federal housing areas.

Earlier this week California Physicians' Service met with the representatives of the Federal Public Housing Authority, the local housing authorities in various areas, Procurement and Assignment Service, California Medical Association, U. S. Public Health Service, and several other Government agencies. The net result of this meeting was that all those present recognized the seriousness and urgency of the situation and agreed that more adequate financial arrangements must be provided by the housing authorities.

Those at the meeting adopted unanimously a resolution which requests the Federal Public Housing Authority to authorize the local housing authorities to negotiate contracts with California Physicians' Service on a basis which will allow California Physicians' Service to operate on a financially sound basis, with additional funds for such service to come from some source which is not now being utilized. Ways and means of raising adequate funds were left entirely in the hands of the housing authorities.

On the basis of the demand from California Physicians' Service to the housing authorities, it appears only reasonable to assume that within the next two months we can all count upon one or the other of two alternatives: (1) that professional members of California Physicians' Service will receive adequate payment of units of service rendered for housing area residents, or (2) that professional members of California Physicians' Service will no longer be asked to accept these patients on the basis of California Physicians' Service units.

From all indications we can look forward to a speedy settlement of this problem. It is hoped that our members will exercise due discretion and judgment in their own courses of action during this short period.

Meanwhile, the regular California Physicians' Service program continues the improvement noted some months ago, and we hope that your members will recognize the regular program as entirely separate from the housing area program and will continue their support of the improved regular program.

Fraternally yours,

PHILIP K. GILMAN, M. D.,
Chairman of the Council.

National Tuberculosis Association

In 1904 a group of four hundred far-sighted physicians and laymen organized the National Tuberculosis Association. Their fundamental purpose was to ultimately control tuberculosis. At that time they had no means of raising funds, nor were all communities being organized. As you may remember, in 1907 Emily Bissell borrowed the idea of the Christmas Seal as a fund-raising method. This resulted in coöperation between the American Red Cross and the National Tuberculosis Association until 1920, when the National Tuberculosis Association became the sole proprietor of this unique method of raising funds.

The National Tuberculosis Association, through annual contracts, authorizes the state, territorial, and local associations to conduct the seal sale and to carry on activities for the control of tuberculosis. Five per cent of the gross proceeds from all money raised by the local associations goes to support the National Tuberculosis Association.

The National Tuberculosis Association assumes leadership in formulating policies which ultimately will control tuberculosis. Their funds are expended on health education, research and study, organization and administration, and publications of medical and health education material.

Profession or Trade.—The medical profession deserves the grateful recognition and regard of all other callings in modern life. It has always insisted that the practice of medicine is a profession and not a trade. Trade is occupation for livelihood; profession is occupation for the service of the world. Trade is occupation for joy of the result; profession is occupation for joy in the process. Trade is occupation where anybody may enter; profession is occupation where only those who are prepared may enter. Trade makes one the rival of every other trader; profession makes one the coöperator with all his colleagues.—President Faunce, of Brown University, in an address to the Rhode Island Medical Society, 1905.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings[†]

California Medical Association. Place and date of the seventy-third annual session, to be held in 1944, to be announced later.

* * *

American Medical Association. Place and date of 1944 annual session to be announced later.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts[*]

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a. m., under the title "Your Doctor and You."

In August, KFAC will present these broadcasts on the following Saturdays: August 7, 14, 21, and 28.

The Saturday broadcasts of KECA are given at 10:45 a. m., under the title "The Road of Health."

"Doctors at War":

Radio broadcasts of Doctors at War by the American Medical Association in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy are on the air each Saturday at 2 p. m., Pacific War Time.

Pharmacological Items of Potential Interest to Clinicians[*]:

1. *Once Again, Here's to You, Herbert:* University of California Press, at $10, offers a choice collection of forty-eight papers on physiology of reproduction, nutrition, and endocrines, and on the history of medicine and science, *Essays in Biology in Honor of Herbert M. Evans.* From Allen, through Fulton, Houssay & Turpeinen, to Zondek, the essayists have given Herbert a grand sixtieth birthday. Don't miss one; they are all first class. The volume is a "must" for any library.

2. *Other Books:* H. F. Blum offers *Photodynamic Action and Diseases Caused by Light,* an excellent survey (Reinhold Publishing Company, New York City, $6). F. J. Wampler edits for Williams & Wilkins, Baltimore, $6, the *Principles and Practice of Industrial Medicine,* with chapters by thirty-two experts. Basic and hot is H. A. Abramson, L. S. Moyer, and M. H. Gorin's *Electrophoresis of Proteins and the Chemistry of Cell Surfaces* (Reinhold Publishing Company, New York City). Tops is *Proteins, Amino-Acids and Peptides as Ions and Dipolar Ions,* by E. J. Cohn and J. T. Edsall (Reinhold Publishing Company, New York City). The Commonwealth Fund (41 E. 57th Street, New York 22) issues D. O'Hara's *Air-Borne Infection: Some Observations on Its Decline.* On the sweetness and light side is B. W. Overstreet's *Courage for Crisis* (Harper's, New York). J. B. Lippincott, Philadelphia, refer to L. K. Ferguson's *Surgery of the Ambulatory Patient* as the book of the year. From the Macmillan Company, Cambridge University Press Division, New York City, comes the announcement of the intriguing *Anonymous Londinensis,* a translation by W. H. S. Jones of second century papyrus, giving extracts from twenty-five ancient medicos. Also, for $5.50, the important *Permeability of Natural Membranes,* by H. Davson and J. F. Danielli. And C. E. Raven's *Science, Religion, and the Future.* Noticed the increase in manuals of tropical medicine and parasitology? Annual Reviews (Vol. XII, Biochemistry; Vol. 5, Physiology, Stanford University, California) are up to their usual standards. For the American Library Association, Chicago, Janet Doe of the New York Academy edits a *Handbook of Medical Library Practice,* which, let us hope, will not become pontifical.

3. *Shock:* F. R. Winton & Co. describe injury to kidneys from traumatic shock (*Quart. Jour. Exp. Physiol.,* 32:89, 1943). M. C. Winternitz & Co. show significant rise of serum phosphate in traumatic shock and demonstrate shock-like symptoms from phosphate administration, and then indicate beneficial effect of intravenous sodium succinate (instead of glucose) with plasma (*Am. Jour. Physiol.,* 139:299-324, 1943).

4. *Cancer:* J. K. Parnas succinctly reviews coenzymatic reactions (*Nature,* 151:577, May 22, 1943). The excellent work of the McArdle Laboratory at Wisconsin results in W. C. Schneider and V. R. Potter proposing theories of biocatalysis in cancer tissue (*Cancer Res.,* 3:353,1943). I. H. Perry, L. A. Strait, and E. L. McCawley put across a neat California report on a spectrochemical study of estrogen-induced mammary cancer (*Ibid.,* pp. 370-384). C. Huggins discusses the endocrine control of prostatic cancer (*Science,* 97:541, June 18, 1943).

[†] In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

[*] County societies giving medical broadcasts are requested to send information as soon as arranged.

[*] These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School, Galveston, Texas.

5. *Alia:* W. Hughes and F. Murgatroyd discuss drug control of malaria (*Lancet,* 244:699, June 5, 1943). Vale to Warrington Yorke (1883-1943), brilliant chemotherapist! M. M. Sheniakin & Co. (Moscow) (*Nature,* 151:585, May 22, 1943) also propose a redox mechanism for vitamin K activity, like E. L. McCawley and C. Gurchot (*Univ. Calif. Pub. Pharmacol.,* 1:325, 1940). E. C. Dodds & Co. naturally would note morphine-like action of diphenylethylamines (*Nature,* 151:614, May 29, 1943). W. S. McClellan of Saratoga Springs would also naturally observe new trends in the treatment of chronic disease, recounting an experience in Spa therapy (*Ann. Int. Med.,* 18:825, 1943). E. A. Doisy & Co. report that penicillin B is a flavoprotein enzyme causing oxidation of glucose to gluconic acid and hydrogen peroxide, the latter being antibacterial (*J. Biol. Chem.,* 148:365, 1943). The J. R. Gallaghers and L. Brouha give dope on dynamic physical fitness in adolescents (*Yale J. Biol. Med.,* 15:657, 1943). G. A. Emerson finds that ventricular fibrillation from digitalis is not adrenergic (*Proc. Soc. Exp. Biol. Med.,* 53:12, 1943).

Doctors of Medicine as Others See Them.—"During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest."

The above item, with some quotations, appeared in CALIFORNIA AND WESTERN MEDICINE: July, 1942, issue, pp. 108-109; October, pp. 269-270; November, pp. 287 and 331-332; January, 1943, issue, pp. 49 and 50; February, pp. 92-93; April, pp. 255-257; May, pp. 305-308; and July, p. 96. More recent items follow:

A TRIBUTE TO MEDICAL MEN: PRAISE FROM A GENERAL

Lieutenant General Lesley James McNair, Commander of Ground Troops in the United States, wounded while visiting the African front, had the following to say of the American doctors in that scene of action: "The medical service was superb. I know at first-hand the speed and efficiency with which they worked. I was wounded at 2:30 in the afternoon. Within ten minutes they had me at a Battalion Aid Station. There two medical officers put a tourniquet on my shoulder to stop the bleeding, bandaged me, fixed me up so I could be taken to the rear. I went from there in a jeep to the Division Clearing Station, where they gave me blood plasma and checked my dressing. They put me on a litter in an ambulance and started me farther to the rear. At 5:30, only three hours later, I was in a field hospital, had been treated twice, had had x-rays taken, and was ready to be operated upon. That evening I came to in a warm bed, with no after-effects from the operation. . . . I didn't get this sort of treatment because I was a general officer. Buck privates were getting the same care."

The medical men who attended General McNair in Africa were merely civilian doctors not many months ago following routine practices at home. The service which they are now rendering to the troops—general and private alike—they were rendering to civilians. On the military front, as on the home front, these medical men know only one kind of service—the best possible. That is the tradition in which they have been trained.—San Francisco *Organized Labor,* July 17.

* * *

TRUE TO TRADITION

American doctors have long been leaders in alleviation of human suffering. True to tradition, they are now giving unparalleled medical service to our soldiers at the front.

Brigadier General George F. Lull, personnel officer in the Surgeon-General's office, estimates that 3,000 American doctors will be disabled every year in service, and be returned to civilian life. The doctors are right with the fighting men getting the wounded off the battlefield and from there to base hospitals. It is the remarkable rapidity with which men are cared for after their injuries that has caused the miraculously low mortality rate in American casualties.

Based on the initiative American Medicine has shown in bringing the benefits of medical science to all the people, the record it is making in this war is but logical progress toward the goal it is constantly seeking to reach—the maximum saving of life and elimination of suffering.—Chico *Enterprise,* July 6.

* * *

SERVICES OF PHYSICIANS REASSURE

My hat is off to our American medical men in the service and on the home front alike. Figures recently released by the Government on the percentage of recoveries from wounds in the present conflict reveal an interesting and encouraging picture.

Certainly it should be a source of comfort to the parents and relatives of the boys in the armed forces to know, for instance, that approximately 53 per cent of those who were wounded up to a recent date had been returned to duty and that about 43 per cent were still under treatment in Army and Navy hospitals. Less than one per cent were invalided from service and deaths occurred in slightly more than two per cent of the cases.

All of this speaks most highly for the advancement of medicine and the skill and training of the physicians and surgeons now in active service and those at home who are discovering new cures and methods by constant study and long hours of work and research.

There are many life-saving devices entrusted to the men themselves and to the hospital corpsmen which may account for a high percentage of saving and sustaining life until the nurses and doctors arrive upon the scene.

For instance, the first-aid packet which contains certain tablets of an improved sulpha ingredient, and sulpha powder to be used on wounds. These kits are so arranged that a wounded man may open and apply them if necessary before the hospital corpsmen arrive.

When one considers that modern warfare does not have rigid and distinct battle lines and that opposing forces are continually on the move back and forth, from flank to flank, over mountains and down valleys, one begins to grasp the mobile and flexible attributes of the modern medicine and hospital units and the war training which medical officers and nurses must undergo.—Sonora *Union Democrat,* July 9.

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WILL NOT FORGET

It is often said that war is harder for those who remain behind than for those who go. Millions are now experiencing the sleepless nights, the ceaseless worry of remaining at home while others go to war. No small source of concern over loved ones in the service is the fear that they may not receive proper medical care. This can be dispensed with. The men in military service are receiving the best that medical science can give them.

In reviewing the military medical record of the first year after Pearl Harbor, *The Journal of the American Medical Association* says: "During the year the only serious incident from a medical point of view was the jaundice associated with inoculation against yellow fever. The first week of February, 1943, found atypical pneumonia and meningitis most prominent of the infectious diseases, but even these were scattering, with a few cases here and there, and only a score or slightly more of cases of either in the few camps most seriously affected. . . . Since January, 1941, and up to now, excluding battle casualties, the death rate has been the lowest in the history of our Army. During World War I, one patient of each three with meningitis died; now only one in twenty dies. Prompt diagnosis, efficient care and sulfonamides have made the difference."

The American public owes a debt of gratitude to the medical men that it will never be able to fully repay. The countless thousands of men who will return after the war, thanks to the skill of doctors serving in the front lines, will not forget that debt.—Corning *Observer,* June 23.

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The Doctor Goes Aloft

A few years ago the dreams of men who proposed four hundred mile an hour combat planes which functioned efficiently at 40,000 feet would have been scoffed at as impossible. Even if the planes were devised capable of such performance, what of the human element? It was thought no person could stand the strain. No person could then. But medical science managed to keep abreast of aircraft development. Planes and men fight today in the stratosphere at ear-splitting speeds. They fight at altitudes where the air is so rare, exposure means death in a matter of seconds.

It was recently pointed out in *Hygeia* that "An airman—this applies to men on the ground staff as much as to flying crews—who is obviously suffering from strain finds in the medical officer a personal friend anxious to assist him in every respect. The doctor usually knows most of the flying men of his squadron by name. By studying their records, documents, and flying logs, he can always keep himself informed of their progress."

It is no idle assertion that modern air power is dependent upon modern medicine.—Isleton *Delta News,* July 2.

* * *

While Others Cheer

When the prospect of peace becomes more real, literally hundreds of millions of people will stand ready to join in a deafening tumult of relief and happiness. Victor and vanquished alike will revel in a reunion with loved ones.

But there is one group whose shouting will be muted—the doctors. For them the job of rebuilding the shattered wreck that humanity has made of itself and the world will begin. Many of them will not be able to return home. They will have to stay in far-away places battling as they never battled during the war, against disease and starvation. They will have to work against time to develop new aids and new techniques in a world-wide struggle to control the spread of fearsome maladies. These men in white know that the war has created medical problems which if not solved could easily make the war itself look like a pink tea. No, the doctors will not cry out in care-free happiness when this war ends.

Laymen, who know so little of the grim task the doctors face, should endeavor to ease their burden wherever possible. The standards of our medical men are high. They serve rich and poor alike to the best of their ability, and the ability of American doctors is not surpassed. We should reflect soberly on these things in the years ahead when the doctors will be fighting the greatest battle of all time.—Woodland *Echo,* July 30.

Four-County Medical Society Meeting at Sonoma Golf Club.—On Thursday evening, July 29, at the Sonoma Golf Club, the annual Four-County meeting (Sonoma, Solano, Napa, and Marin counties) was held. The meeting was given over to goodfellowship and a discussion of organization topics. Dr. William N. Makaroff of Guerneville presided.

Talks were made by: Karl L. Schaupp, President of the California Medical Association; Dwight H. Murray of Napa, Chairman of the California Medical Association Committee on Legislation; Councilor John W. Green of Vallejo; Past President Henry S. Rogers of Petaluma; Secretary-Editor George H. Kress; Legal Counsel Hartley F. Peart; Executive Secretary John Hunton; Secretary of California Public Health League, Ben Read.

The occasion was graced by a goodly number of colleagues in military service who had come over from the Mare Island Hospital and other posts.

State Senator Herbert W. Slater of Santa Rosa, who was also one of the speakers, emphasized the importance of keeping legislators properly oriented on public health needs.

Rationed Foods for Hospital Patients.—While the wartime need of conserving rationed foods is great, no hospital patient need suffer from inability to get foods required for his health, the Office of Price Administration recently announced.

The OPA is sending specific instructions highlighting this point to all local War Price and Rationing Boards, and to other OPA field offices. For several months, OPA and medical authorities have been studying the hospital problem with a view to developing a uniform procedure covering the granting of supplemental allotments for hospitals. Solution of the problem is believed near.

"In the meantime," OPA said, "a provision in the regulations (Section 11.6 of General Ration Order 5) should enable hospitals to obtain the necessary supplemental allotments so that no patients shall suffer from dietary deficiency. This provision gives local boards authority to grant such allotments to meet the dietary requirements of patients living in, and receiving care in, hospitals, whether or not such patients are on special diets.

"In determining the amount of the supplemental allotment of processed foods and the commodities covered by Ration Order 16, the local board will take into consideration the availability of fresh fruits and vegetables, unrationed substitutions such as poultry and fresh fish, and the physical facilities of hospitals to process and store such foods."

Administrative officers of hospitals had complained that local boards in some cases had confined the granting of supplemental allotments to situations covering patients on special diets.

"Section 11.6 of the ration order does not limit the granting of relief so narrowly," OPA explained. "No hospital patient need suffer from inability to get food because of rationing."

Notes from the Food Rationing Committee of the San Francisco County Medical Society.—The Medical Advisory Committee of the Food Rationing Division of the OPA has met regularly each Thursday evening and has checked many special food applications. In general, the requests for extra rations have been most reasonable and conservative. Certain suggestions have presented themselves:

1. The Advisory Committee, desirous of coöperating with our Government's food plans, believes that it is necessary to use all precaution in the conservation of processed foods, particularly at this time. The Committee is convinced, after due investigation, that water-packed fruits and vegetables are not essential in a diabetic diet when fresh fruits and vegetables are available. Fresh fruits and vegetables are incorporated in measured diets with the same facility as are water-packed materials. It is, therefore, urged that physicians do not request water-packed foods for diabetic patients except when complicating factors de-

mand them; such complicating factors should be stated plainly and concisely.

2. In requesting additional meat, it is extremely important to specify the type; that is, beef, veal, lamb, pork or liver, as the point value on beef is practically double that of most of the meats. Likewise, beef should not be specified except where it is most essential, as the supply is very limited and the patient may not be able to obtain the beef for which he has points.

3. Please request foods in pounds or ounces rather than points, as point values change constantly.

4. Please prescribe extra foods on the basis of medical diets rather than upon an economic basis.

American Board of Otolaryngology.—Attention is directed to the letter printed in the July issue of CALIFORNIA AND WESTERN MEDICINE, on page 103, in which the following announcement was made:

"The American Board of Otolaryngology will conduct an examination in Los Angeles on February 2 to 5, 1944, following the meeting of the Midwinter Clinical Course of the Research Study Club, provided at least fifty applicants are accepted. It is urgently requested that applications be submitted immediately so that the Board may plan accordingly. Address all applications to Dean M. Lierle, M. D., Secretary-Treasurer, University Hospital, Iowa City, Iowa.

"The Thirteenth Annual Midwinter Postgraduate Clinical Course of the Research Study Club of Los Angeles will be given from January 17 to 28 inclusive, 1944, to be succeeded by the special course in Applied Anatomy and Cadaver Surgery of the Head and Neck, to follow immediately after the Clinical Course. Both courses afford an unusual opportunity for members applying to the American Board of Otolaryngology to obtain an up-to-the-minute refresher course just prior to their examination."

Dinner to Dr. Esther Rosencrantz.—Honoring Dr. Esther Rosencrantz, a formal dinner was given by fifty of her medical colleagues at the Palace Hotel, San Francisco, Friday, July 9, the occasion for the testimonial being her retirement from the University of California Medical School after thirty years' service.

For seventeen years, between 1920 and 1937, Doctor Rosencrantz was Chief of the Tuberculosis Service at the San Francisco City and County Hospital; and at the time of her retirement she was associate professor of medicine and lecturer in medical history and bibliography at the Medical Center in San Francisco. The following is a résumé of her record:

Dr. Esther Rosencrantz, '04, Johns Hopkins, after her intern year at the New York Infirmary for Women and Children, was assistant in the out-patient department of Brompton Hospital for Consumption and Diseases of the Chest, London, England, in 1906-07. She worked two years at the Tuberculosis Clinic, New York City Health Department, and then spent a year at the Charité Hospital, Berlin. From 1910-11 she was a research worker at the Pasteur Institute, under Calmette; then for a year was intern at the Sanatorium de Bligny, France, and after that research worker at Insel Spital, Berne, Switzerland, under Professor Sahli. From 1913-37 she was on the staff of the University of California Medical School, and retired as associate professor of medicine. From 1920-37 she was in charge of the Tuberculosis Service at the San Francisco City and County Hospital. Her greatest honor was a decoration from the Italian Government in recognition of her splendid services as a member of the Red Cross Tuberculosis Commission to Italy in 1918-19. Later Doctor Rosencrantz was consultant to the Arequipa Sanatorium, San Luis Obispo County Tuberculosis Sanatorium, Hassler Health Home, and the Tuberculosis Service of the University of California Hospital and the San Francisco Hospital.

The following doctors were speakers at the dinner: Philip H. Arnot, Jessie L. P. Delprat, Herbert M. Evans, Jacob C. Geiger, Portia Bell Hume, Robert T. Legge, Sophie M. Loven, Earle M. Marsh, Karl M. Meyer, and Angelina Piscitelli. Dr. Jesse Carr was toastmaster.

Doctor Rosencrantz has been a noted collector of the works of Sir William Osler, whose pupil she was at Johns Hopkins Medical School; and at the dinner in her honor she was presented with six of the rarest Osler items. Doctor Rosencrantz has given her Osler collection to the University of California Medical School. At the dinner Dr. Hans Barkan, of the Stanford University Medical School, presented for the collection an original portrait-sketch of Sir William Osler by the famous painter, John Singer Sargent.

Noncongestive Glaucoma: Prize Contest.—The National Society for the Prevention of Blindness announces that a prize of $250 will be awarded for the most original paper adding to the present knowledge about medical treatment of noncongestive glaucoma. Papers should be in the office of the Society, 1790 Broadway, New York City, by September, 1944. (This prize is being offered in addition to one that was previously announced for the most valuable original paper concerning the diagnosis of early glaucoma.)

The award will be made by the Society with the guidance of an ophthalmological committee composed of Doctors Evans, Keil, Kirby, McLean, Reese, Samuels, Schlivek, Schoenberg, and Webster.

American Congress of Physical Therapy.—Will hold its twenty-second annual scientific and clinical session on September 8, 9, 10, and 11, 1943, inclusive, at the Palmer House, Chicago. Rehabilitation is in the spotlight today. Physical therapy plays an important part in this work. The annual instruction course will be held from 8:00 to 10:30 a. m. and from 1:00 to 2:00 p. m. during the days of September 8, 9 and 10, and will include a round-table discussion group from 9:00 to 10:30 a. m., Thursday, September 9. The scientific and clinical sessions will be given on the remaining portions of these days and evenings. A feature will be an hour demonstration showing technique from 5:00 to 6:00 p. m. during the days of September 8, 9, and 10. All of these sessions will be open to the members of the regular medical profession and their qualified aids.

For information concerning the instruction course and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

Our Mineral Springs.—Awaiting development in times of peace as among the greatest natural resources are the four hundred or more natural springs in California.

The healing values of some of these springs have been proved through years of use and trial. In the belief that with the close of the war there will be increased opportunities to bestow benefits, our State Chamber of Commerce, the League for the Development of California's Mineral Springs, the State Legislature, and others, are directing new attention to assets of a kind which in other countries have been highly valued and internationally publicized.

Practically all that which has been done in the interest of promoting our springs was started four years ago when the State Chamber placed the program on its agenda, and two years ago when the League was organized. These were programs of normal times, anticipating no federal coöperation, and stressing largely the attractions which would be offered to tourists.

At present, it is believed that many of these springs, with their values authenticated, will render services much larger. For that reason, the recent Legislature, by joint resolution, has asked the President, members of Congress from this State, and the surgeons general of the Army and Navy to institute investigations concerning the advantages that would accrue to the patients if one or more military hospitals of convalescent or other nature were erected in the mineral springs areas.

It may well be that some of these springs, which were known to the Indians for their properties long before the white men came may offer special advantages in recovery of the health and rehabilitation for invalid soldiers and sailors suffering from shock or nervous or other disorders incident to the war experiences. If there is that possibility, it is entirely proper that the State ask the medical authorities of the military, and others, to undertake an inquiry.

In European countries and in the United States, at Saratoga Hot Springs in New York, and in Arkansas, mineral springs and the spa treatment have been abundantly tested and approved. The springs of California, situated among beautiful surroundings and in a region of beneficent climate, have long awaited recognition and the chance to demonstrate their values.

For some years, it would seem certain, Americans who used to follow the impulse will not be able to visit the spas of Europe, and for some years it will be the duty of this country to supply the best of care and environment to the convalescents of the war. In the program the mineral springs of California may be destined to have a large part.—Oakland *Tribune,* June 2, 1943.

Gestation Data for Guidance of Draft Boards.—For the guidance of draft boards, the American Medical Association on May 7 said that if the father of a child born after September 15, 1942, claims that the infant was conceived before Pearl Harbor, the burden of proof should rest with the father.

The American Medical Association Journal said that children born after the September 15 deadline could be assumed safely to have been conceived after December 8, 1941, unless there is overwhelming medical evidence to the contrary.

Recent studies of 9,000 women have set the average period of gestation at 285 days, the *Journal* said.

"French law recognizes the legitimacy of a child born 180 days after marriage and 300 days after the death of the husband; the German law, 181 days and 302 days, respectively. In England, in 1921, the legitimacy of a child born 331 days after the husband went to war was allowed. In the United States each case is decided on its own merits."

American Longevity Continues to Increase.—The average length of life of the American people has increased by almost one-third since the beginning of the century. According to health conditions prevailing in 1941, the people of this country had an average length of life, or expectation of life at birth, of 64.36 years—a gain of more than fifteen years since 1901. The record has been especially good for white females, who, in the last four decades, have added 17 years to their expectation of life at birth, as against 15.16 years for white males. By 1941, white females attained an average length of life of 68.08 years, just two years short of the biblical three score and ten. For white males the figure was 63.39 years, or about 4⅔ years less than that for white females.

The record shows that colored persons have made greater gains in longevity than have the white. The expectation of life at birth for the colored increased by 21⅓ years since the turn of the century, while the gain for white persons amounted to 16 years. This fact notwithstanding the current longevity among colored persons is still ten years less than that for the white, and is now only at the level of that for white persons a quarter century ago.

The most substantial gains in extending the average length of life have been made in childhood, adolescence, and early adult life. Stated in terms of mortality, the rates in 1941 at ages below 40 were well under one-half those at the beginning of the century. In the first year of life and at ages from 10 to 30, the current rates are one-third those in 1901; at age 5 they are only one-fifth. One must not assume, however, that death has retreated only at the younger ages. Improvements in mortality have been appreciable even after age 40. For example, at age 45 the death rate in 1941 was three-fifths that in 1901; at ages 50 and 55 the ratio was about three-quarters. The gains in expectation at age 40, by sex and color, are given in the right-hand panel of Table I. These figures give little comfort to the prophets of doom, who claim that the race is deteriorating physically because scientific and social advances interfere with the laws of natural selection. On the contrary, such conservation of our human resources contributes basically to our security.

As a result of the current favorable health situation, about 60 per cent of the large crop of babies now being born will live to attain age 65; according to conditions prevailing in 1901 only 40 per cent might have been expected to attain that age. It is possible to make an even more graphic contrast of the change in longevity that has taken place. Mortality in 1901 was such that one-quarter of the babies would have died before attaining age 25. But with the conditions in 1941, age 57 would be reached before that proportion died.

Although 1941 is the best year on record as regards longevity, there are indications that when the figures for 1942 become available they will show an equally good record. On the whole, health conditions have been very favorable despite the growing shortage of civilian physicians, the initiation of restrictions on food consumption, and the crowding of people in centers of war industries with inadequate housing facilities. . . . — Metropolitan *Statistical Journal,* April, 1943.

Compulsory Sickness Insurance. — "A. W. Eckman, at the meeting of the Christian Science Church in Boston on June 7, 1943, manager of the committees on publication, reported that state, provincial, and national legislative bodies had dealt fairly with Christian Science activities. But he cautioned that there was an increasing tendency in legislative halls to impose blanket regulations involving compulsory sickness, disability and hospital insurance which would bring about indirect compulsion upon Christian Scientists to accept medical treatment."—San Francisco *Chronicle,* June 8, 1943.

State Attorney-General Kenny Rules on Drugless Practitioners. — Drugless practitioners may legally sign death certificates, Attorney General Robert W. Kenny ruled yesterday in an opinion given to the Board of Medical Examiners.

"A drugless practitioner receives his license from the Board of Medical Examiners," Kenny wrote. "By law, the mode of treatment employed by him is recognized. It is difficult for me to believe that a drugless practitioner in attendance on a patient should not be qualified to file the certificate of death as well as the medical certificate.

"It should, of course, be realized that the implication is not to be conveyed that drugless practitioners may call themselves or advertise themselves as 'physicians' or that they may practice 'medicine.' "—Los Angeles *Daily News,* June 23.

Lemon Now Is Source of Pectin.—Now you can get a transfusion from a lemon.

Before you hasten to build up your blood supply by taking your lemons in a medicinal mixture from a tall glass, be warned that the lemons are first reduced to pectin, in which form it is valuable replacement for blood plasma.

A two months old rabbit who probably wouldn't even twitch his nose at a lemon of his own accord is thriving with one-third of his rabbit blood replaced by the lemon kind—sterile pectin solution.

The California Fruit Growers' Exchange, who calculatingly converted the nation to drinking up an orange surplus, thought it up. Their laboratory and clinical studies were confirmed by less citrus-minded medical authorities.

The April 24 issue of *The Journal of the American Medical Association* reports on use of lemon pectin instead of plasma in treatment of human beings suffering shock.—Santa Cruz *Sentinel-News,* May 6.

2,628 Gain Made in Doctor Total.—There was a net gain of 2,628 physicians in the United States last year, *The Journal of the American Medical Association* reported.

Statistics gathered by the American Medical Association's Council on Medical Education and Hospitals, and based on new licenses and certificates issued in 1942, showed 5,981 physicians were added to the profession's population. During the same period, 3,353 deaths were recorded.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Social Change To Be Slow, Senator George Says

Vienna, Ga., July 31.—(AP)—Senator Walter F. George (D., Ga.), chairman of the Senate Finance Committee, commended today President Roosevelt's six-point plan to aid returning service men, but predicted that the Congress would be cautious in expanding the nation's social security program.

Observing that existing laws provide for rehabilitation of soldiers and sailors after the war, George suggested in an interview that the President "has in mind a greatly expanded social security program."

"Notwithstanding the great humanitarian impulse to greatly extend the social security system," he continued, "we will proceed slowly in the United States to expand any program which is dependent on a capital levy."

He argued that social security taxes must be paid by business whether it runs in the black or in the red, and thus is capital taxation.

"With a sound system of taxation that allows individuals and business to accumulate reserves, we should be able to provide reasonable employment for our people as we have in the past except in periods of unusual depression. A social security system, properly enacted, would soften the blow in such periods.

"Any social security system must depend on prosperous business—all business, from farming on up the scale—and if we haven't got prosperous business, we cannot have social security on the European scale.

"If we have prosperous business, we don't need to make the people dependent on their government. That, at least, is the American way, and if that passes, we will go to a different social and political system in America."—San Francisco *Chronicle,* August 1.

State Population of 10,000,000 Is Predicted for California

Sacramento, July 21.—(UP)—Barring unforeseen catastrophe, a California population of 10,000,000 is inevitable by 1950, according to a survey completed today by the State Population Commission.

The report said California was probably third among the States now, having passed Ohio and Illinois since the 1940 census, and predicted that by 1960 it might overtake and pass New York.

California's growth since 1940 was estimated at about 1,000,000, but the commission warned that the State must prepare for an even greater "migration invasion" after the war.

It said that more than 400,000 persons have entered the State by bus lines already this year, and estimated another 400,000 had come in by private automobile.—San Francisco *Chronicle,* July 22.

Health Group Meets: Discusses Poliomyelitis

With eighty-two cases reported in the State, northern California health officials will meet in San Francisco today to consult with Dr. John L. Lavan, research director of the National Foundation for Infantile Paralysis.

State, county and city health officers will attend the meeting, which will be followed on Monday by a similar conference in Los Angeles for southern California medical men.

As the number of cases in the Bay area rose to twenty-five for the week ending July 10, directors of the San Francisco chapter of the Infantile Paralysis Foundation voted $6,000 to equip a ward for polio patients at Children's Hospital during the present emergency.

Health Officer Dr. William A. Powell reported fifteen new cases of infantile paralysis in Contra Costa County since July 1, compared with five in June.—San Francisco *Examiner,* July 15.

Nursing Education Must Be Streamlined

Berkeley, Jluy 26.—Nurses must be prepared more rapidly to supply the needs of the armed forces, according to Miss Margaret A. Tracy, director of the School of Nursing on the Berkeley and San Francisco campuses of the Universty of California. . . .

Training of Red Cross nurses' aides has shown that the nursing techniques on which a student normally spends 75 per cent of the time can be mastered in a relatively short period by intelligent individuals. There are differences of opinion as to how much time should be required in practice in the various clinical fields. By shortening the interval in each it might be possible to save as much as one year in the nursing course, she says.—*University of California Clip Sheet,* July 20.

U. C. Will Participate in Cadet Nurse Plan

Berkeley, July 21.—One of the participants in the new nursing education program subsidized by the United States government will be the School of Nursing of the University of California. This announcement was made by Miss Margaret A. Tracy, director of the School of Nursing on the Berkeley and San Francisco campuses.

To be known as the U. S. Cadet Nurse Corps, this organization of student nurses was established by a recent act of Congress. The purpose is to supply nurses for civilian health services as well as for the Army and Navy.

The entire cost of the nursing education is to be borne by the Federal Government. This includes uniforms, tuition fees, and monthly allowances to the students. In return, every member of the corps must agree to remain in nursing service for the duration. This does not necessarily mean the Army or Navy nurse corps, but may be any essential or public health nursing field.

Students who join the corps must be high school graduates and must satisfy the requirements of the nursing school in which they register.—*University of California Clip Sheet,* July 20.

U. S., Soviet Doctors Plan Coöperation

Wounded soldiers throughout the fighting world, and the sick and suffering for years to come, will know the healing effects of the American Soviet Medical Society, officially launched at dinner in the Hotel Pennsylvania Friday night.

This latest advance in Soviet-American relations brought together more than six hundred distinguished American medical leaders who will coöperate with Soviet doctors for the exchange of medical information through the society, and the American Review of Soviet Medicine, the new magazine which will appear in September.

The guest of honor was Dr. Vladimir V. Lebedenko, leading Soviet military surgeon, in this country as representative of the Red Cross and Crescent of the U. S. S. R.

Describes Soviet Care

"The secret of what Soviet medicine has accomplished," said Doctor Lebedenko, "is largely the secret of organization, plus the putting into operation on a large scale of everything science has achieved." He described how Soviet medical advances have enabled 75 to 80 per cent of the wounded to return to service.

Doctor Lebedenko paid tribute to the president of the new society, Dr. Walter D. Cannon, Professor Emeritus of Physiology, Harvard, and a member of both the United States and the U. S. S. R. Academy of Sciences.

Practically every branch of medicine, and every race and creed have joined to launch the American Soviet Medical Society.

Dr. Henry E. Siegrist, director, Institute of the History of Medicine, Johns Hopkins University and editor of the new magazine, was chairman. Maurice Hindus told of his experiences at the Soviet fighting fronts. . . . —San Francisco *People's World*, June 24.

Doctor Brockway Takes Over Riverside Clinic

Dr. Alvia Brockway, assistant chief of staff of the Orthopedic Hospital, Los Angeles, conducted his first clinic for the Riverside County Health Department Wednesday at the Community Hospital.

Doctor Brockway takes the place of the late Dr. Robert L. Carroll, who made semi-monthly visits to Riverside over the past five years. . . .—Riverside *Enterprise*, July 9.

Women Advised to Follow Medicine

New York, July 22.—(AP)—If it's a high paying job milady's looking for, the medical profession is the best bet and New Mexico is the spot to set up business.

So says the National Federation of Business and Professional Women's Clubs which surveyed the feminine employment field and found women physicians on top followed, in the professional field, by lawyers, accountants and librarians.

Teachers, for the most part, struggle along in the lowest income brackets, the federation said. In clerical jobs, secretaries lead, but stenographers and bookkeepers are fairly close in earning power.

Federation members, classified according to states, show proportionately more women in New Mexico than in other states are making over $10,000. Washington, D. C., and New York follow.

In Vermont, however, 47.3 per cent of those reporting earn less than $1,000. Proportions in this category are almost as high for Arkansas and Kansas.

Of 227 doctors, surgeons and osteopaths covered in the survey, thirty-seven reported $5,000 to $10,000 yearly incomes. Eight said they made more than $10,000.

The average physician's pay is $2,835.50 as against $1,547.50 for the entire professional group and $1,408 for business and professional women combined.

More than half of the school teachers reporting draw less than $1,500 a year.

Out of more than two thousand secretaries, seven are in the $5,000 to $10,000 bracket and two earn more than that.—Fresno *Bee*, July 22.

Diplomas for Sixty-One Doctors

Sixty-one young doctors who during the last year have completed their internship at the Los Angeles General Hospital and who are now serving in the armed forces, are soon to be mailed diplomas, Arthur J. Will, director of county institutions, announced today.

Will said the county hospital is playing a major rôle in training doctors and nurses for the military. He said there were double the number of internes and nurses in training now than in normal times.

"Just as soon as they complete their internship they are inducted into the armed forces and it is almost impossible to retain a few as resident physicians," Will said.—Los Angeles *Herald and Express*, July 23.

Thomas Jefferson on War.—We fight not for glory or for conquest. We exhibit to mankind the remarkable spectacle of a people attacked by unprovoked enemies, without any imputation or even suspicion of offense. They boast of their privileges and civilization, and yet proffer no milder conditions than servitude or death. In our native land, in defense of the freedom that is our birthright and which we never enjoyed till the late violation of it, for the protection of our property acquired solely by the honest industry of our forefathers and ourselves, against violence actually offered—we have taken up arms. We shall lay them down when hostilities shall cease on the part of the aggressors and all danger of their being renewed shall be removed, and not before.—Thomas Jefferson in 1775.

And there I began to think, that it is very true which is commonly said, that one half of the world knoweth not how the other half liveth.

—Rabelais, *Works*. Bk. ii, ch. 32 (1532).

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Judicial Control of Disciplinary Action by the State Board of Medical Examiners

The extent of control which a court may properly exercise over a decision of an administrative board, such as the Board of Medical Examiners, has been a troublesome question in California for some time.

The problem has been twofold: first, the nature of the remedy in the courts to one aggrieved by an order of such a board; and, second, the scope of that remedy.

Because of numerous decisions that an administrative board could not exercise judicial functions, and could not act as a court of law, it was held that no direct appeal could be taken to a court from a decision by a State Board disciplining a member. It was determined that the proper remedy, if a person desired to place before the courts the action of a board, such as the Board of Medical Examiners, was an application to the Superior Court for a writ of mandamus wherein an applicant who had been deprived of his professional license sought an order of the court directing the board to restore his license.

The question which then arose was the importance to be accorded by the court to the hearing before the State Board, and whether the court was confined to a consideration only of the evidence presented before the board with no power to hear new evidence presented by either side. It was held in two cases—one involving the State Board of Funeral Directors and a second, involving the State Board of Optometry—that the Superior Court, in considering an application for a writ of mandamus overruling the action of the State Board, was not confined to the record of the proceedings before the Board, and that the applicant was entitled to a completely new hearing before the Superior Court, designated a *trial de novo*.

A recent decision of the State Supreme Court, *Dare* vs. *Board of Medical Examiners*, 21 A. C., 854, further interpreted this rule as applied to the Board of Medical Examiners. The petitioner in that case alleged that he was licensed as a drugless practitioner under a certificate issued by the Board of Medical Examiners; that he was licensed to practice chiropractic under the provisions of the Chiropractic Act, and that he held a certificate as a clinical laboratory technologist. In May of 1940, he was charged with displaying a sign using the prefix "Dr." without indicating the type of certificate held. Proceedings were taken before the Board of Medical Examiners, and it was determined that this act constituted a violation of the Business and Professions Code, Section 2409. The Board ordered petitioner's license as a drugless practitioner revoked unless he would agree not to use any form of advertising or designation except the words "Drugless Practitioner." The petitioner brought a proceeding in mandamus, seeking an order by the Superior Court directing the Board to cancel this order.

At the trial of the case, petitioner contended there was no necessity for presenting the record of evidence introduced at the hearing before the Board, and that he was entitled to an entirely new trial by the court, with evidence being heard anew and no consideration being given to the Board's record.

If such a contention had been sustained, the effect would have been to vitiate the acts of the Board and render all proceedings before it meaningless. Notwithstanding the court's warning, the petitioner insisted upon a right to a complete trial *de novo*, and refused to introduce the record of the Board.

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† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

Justice Shenk pointed out, in the court's majority opinion, that although the Superior Court in such a proceeding is not confined to the record of the evidence before the Board and can hear all competent evidence material to the issue involved, it was, nevertheless, incumbent upon the petitioner to produce the record of the Board of Medical Examiners before the court would consider any questions of fact.

The court properly refused to determine the issue, whether or not petitioner's license should be cancelled, as if no hearing had been had before the Board of Medical Examiners. Upon petitioner's refusal to place the Board's record before the court, the application for a writ of mandamus was denied and the order revoking petitioner's license stood unaffected.

The result of the court's decision is to require any person taking into the courts the propriety of disciplinary action by the State Board of Medical Examiners to introduce the record of the Board's proceedings before the court and then prove by a preponderance of the evidence that the decision of the Board was unreasonable and unjust as to him.

LETTERS[†]

Concerning Incidence of Poliomyelitis in California:

(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH

San Francisco, California,
June 18, 1943.

Dear Doctor Gilman:

In line with our conversation on Friday, I am sending you a statement relative to the incidence of poliomyelitis in California.

The following tabulation will give you comparative figures for certain epidemic years and for the last five years:

	Cases Total to Mid-June	Cases Total for Year
1927	134	1,298
1930	336	1,903
1934	1,615	3,396
1939	94	973
1940	168	440
1941	75	237
1942	40	331
1943	203	......

From the course of the disease thus far, it would appear that there would be a considerable increase over the last two years but that the epidemic will not assume the proportions of 1934.

Nobody as yet has been able to tell us how poliomyelitis spreads, but it is generally agreed that prompt reporting, proper segregation of cases, and, more recently, treatment by the "Kenny method," are factors of great importance. There is also a great feeling that exhaustion, undue exposure, and possibly depletion from other causes may be factors in the occurrence of the disease.

The State Department of Public Health has recently circularized the various local communities relative to the number of nurses, doctors, and physiotherapists who have had training in the "Kenny method" of treatment. The number is greater than I had anticipated, and is as follows:

Total Trained M. D.'s	17
Total trained physical therapy technicians	55
Total trained nurses	44

These individuals are giving excellent service in the treatment of cases which are occurring. There are not, however, sufficient to give proper care in the case of a large epidemic, and the Department is taking steps to increase the number of individuals who have had this training.

Sincerely yours,
(Signed) WILTON L. HALVERSON, M. D.
Director of Public Health.

The list which follows indicates the number of cases by counties:

Alameda	10
Contra Costa	5
Fresno	7
Kern	20
Los Angeles	90
Madera	2
Marin	1
Napa	1
Nevada	1
Orange	18
Sacramento	1
San Bernardino	9
San Diego	8
San Francisco	8
San Joaquin	3
San Luis Obispo	2
San Mateo	2
Santa Barbara	1
Santa Clara	6
Santa Cruz	3
Shasta	1
Solano	2
Tehama	1
Ventura	1
Total	203

(See also items on pp. 130-131.)

* * *

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

June 7, 1943.

To the Editor:—A recent study of meningococcus meningitis cases at the San Francisco Hospital during this calendar year has revealed an interesting observation.

As a part of the routine necessary before cases are discharged, a nasopharyngeal culture is taken on each case. This is a difficult procedure requiring accurate technique, the laboratory culture material is expensive, and, of course, it involves the time of skilled technicians.

In the study recently completed, it was shown that we have taken eighty-eight nasopharyngeal cultures on forty-four patients since January 1, 1943. No positive cultures have been reported to date.

Inasmuch as nearly all of our patients at the present time have been given sulfonamide therapy, the question arises that perhaps the use of sulfonamides precludes the possibility of a convalescent carrier state.

In view of the statistics of our experience in taking these cultures, we are at this time discontinuing taking nasopharyngeal cultures as a routine procedure before the discharge of these patients.

Sincerely,
J. C. GEIGER, M. D.,
Director.

* * *

Precautions for Polio

"More than the Usual Number" of Cases Reported Here

With "more than the usual number" of infantile paralysis cases currently reported in San Francisco, Dr. J. C. Geiger, health director, today listed precautionary steps to avoid spread of the disease.

At the same time the State Department of Public Health said thirteen new cases have been reported in the northern California area, bringing the total to twenty-eight for the week ending July 3. Eleven were in Sonoma County and one each in Alameda and San Mateo counties.

Precautions Listed

Doctor Geiger, who said San Francisco had five polio cases in May, four in June and one reported thus far in July, listed these precautions:

[†] CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

1. Thoroughly investigate even a slight illness.
2. Avoid exposure, especially by keeping children from new groups of people.
3. See that children put no soiled objects into their mouths.
4. Swimming may be an important factor in spread of the disease through contaminated water.
5. All cases and suspected cases should be promptly reported to the health officer.

Symptoms of Disease

Doctor Geiger said symptoms accompanying the onset of the disease are "many and varied." Usually present are a moderate degree of fever and the signs of a digestive upset headache, pain and stiffness of the neck and muscle tenderness.

As a rule there is a short period of from one to five days after the acute symptoms subside when the patient may be apparently well, he said. Then, if paralysis is to occur, muscle weakness may be noticeable. Pain in the affected muscles generally precedes paralysis and is a "very valuable sign" if recognized early.

He pointed out that physicians at Stanford, California, Children's and San Francisco hospitals have been trained in the Kenny method, adding that a number of out-of-town cases have been brought here for treatment.

Concerning Medical Publications Sent to Military Camps in California by the California Medical Association Postgraduate Committee:

(COPY)

STATION HOSPITAL
VICTORVILLE ARMY AIR FIELD
VICTORVILLE, CALIFORNIA

3 July, 1943.

California Medical Association
Postgraduate Committee
450 Sutter Building,
San Francisco, California.

Gentlemen:

We wish to take this opportunity to express our appreciation for the medical literature received by this hospital a few days ago.

It has been placed in our library, where it is easily obtainable by the members of the staff. Although it has only been at their disposal a short time, they have found the journals to be very helpful, and I am certain they will continue to find the material even more so, in the future.

The staff members of this hospital join me in expressing our gratitude for your contribution.

For the surgeon:

SAMUEL R. FERRIS,
2nd Lt., M. A. C.,
Executive Officer.

* * *

(COPY)

MEDICAL DEPARTMENT
UNITED STATES NAVAL AIR STATION
SAN DIEGO, CALIFORNIA

June 30, 1943.

California Medical Association
Postgraduate Committee
450 Sutter Street
San Francisco, California

Gentlemen:

The medical literature mentioned in your letter of June 21, 1943, has been received and will be distributed to our outlying air fields.

Your thoughtfulness in sending these journals is greatly appreciated and wish to thank you at this time.

Very truly yours,
L. E. MUELLER,
Captain (M.C.), U. S. Navy,
Senior Medical Officer.

Concerning a Hospital Staff Regulation Limiting Surgical Procedures of Staff Members:

(COPY)

San Francisco, June 9, 1943.

Dear Doctor ———:

Doctor Kress has forwarded to me a copy of your letter of June 1, 1943, in which you request my opinion with respect to the legal status of a physician on the staff of a private hospital.

The general rule of law is that any hospital may, by appropriate rules and regulations, restrict the practice therein in such manner as it sees fit, provided only that each particular rule or regulation must be reasonable and not arbitrary. For example, a rule of a private hospital restricting surgery therein to physicians and surgeons residing withing ten miles of the hospital would stand or fall, so far as the law is concerned, on the question as to whether residence within ten miles was a reasonable or an arbitrary requirement.

The question which you raise in your letter is within this principle of law and the proper answer to it depends upon whether the rule established by the hospital is reasonable or unreasonable. Of course, the question of reasonableness is not one that I can answer, as it requires a professional knowledge which no one other than a physician possesses. It is my understanding that the State Association has taken no stand with respect to the particular problem raised in your letter.

Therefore, it would appear that the matter is one of local jurisdiction and that the Los Angeles County Medical Society is the proper body to reach a decision in the first instance.

Very truly yours,
(Signed) HARTLEY F. PEART.

cc: Dr. George H. Kress, Secretary
California Medical Association.

MEDICAL EPONYM

Riggs's Disease

A paper read before the American Academy of Dental Surgery in New York on October 20, 1875, by John W. Riggs (1810-1885), M.D., F.A.A., D.S., of Hartford, Connecticut, entitled "Suppurative Inflammation of the Gums and Absorption of the Gums and Alveola [*sic*] Process," has served to attach his name to the condition of pyorrhea. This appeared in the *Pennsylvania Journal of Dental Science* (3:99-104, 1876). A portion of the text follows:

"This disease is called by many the disease of old age . . . but at the present day we find the middle aged, and even the young, affected by it . . . one by one the teeth become loose from loss of bony support and are plucked out as an intolerable annoyance. If the inflammatory action be great and involve most or all the gum embracing the teeth, pus tinged with blood exudes from around the necks of the teeth on the slightest pressure of the lips or tongue, or in mastication. The oral secretions become vitiated, present a viscid or sanious character, very abundant in quantity during the day, but much more so in the recumbent position of sleep. If the patient reposes on his side these exudations flow out of the corner of the mouth over the pillow and present in the morning a dried, yellow discoloration, often tinged with blood and covering a space as large as one's hand. If the patient reclines on his back the diseased mass flows back into the fauces and is unconsciously swallowed, then to work a greater mischief. . . . None but the most vigorous constitutions can withstand this type of disease."—R.W.B., in *New England Journal of Medicine.*

TWENTY-FIVE YEARS AGO[†]

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 8, August, 1918

EXCERPTS FROM EDITORIAL NOTES

Venereal Disease.—It is important that the American nonmedical public be shaken out of its false modesty regarding venereal disease. This object is being attained to a remarkable degree as a result of the Army and Navy policy combined with the work of the Commission on Training Camp Activities. We are being forced, as a nation, to take a sane and scientific attitude toward the subject. Syphilis and gonorrhea constitute one of our chief sanitary and public health problems. . . .

Universal Service.—Every patriotic American believes today in universal service as a war measure. This, in the broad sense, simply means complete and efficient organization and mobilization for war of all the resources of the country, both human and material. It means "work or fight" for men in draft age. It means suppression of nonessential activities of all sorts. It means for each man and woman to get the maximum physical efficiency personally. It means a conscious development of individual patriotism. It means intelligent and constructive study of our personal and national ideals. It means scrutiny of national problems and policies. It means informed interest in politics, in social activities of relief and charity, in local and general social problems of civics, morals, religion, and health. It means, in short, a literal reading of the words *universal* service, making every person contribute his utmost to himself and his fellows in the way of physical, intellectual, and moral improvement. *That* is universal service. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Prevention of Blindness Work of the State Industrial Accident Commission," by Will J. French, San Francisco.—The earliest reference to "Safety First" I have been able to find is in Chapter 22, verse 8, of Deuteronomy, the fifth book of Moses, where these words appear: "When thou buildest a new house, then thou shalt make a battlement for thy roof, that thou bring not blood upon thine house, if any man fall from thence."

The foundation of English common law is taken from the five books of Moses, from Genesis to Deuteronomy, and we can there read much that represents the highest ideals of present-day civilization. If they had used emery wheels in those day, I think we would be able to read a verse following the one quoted about like this: "When thou grindest tools on the emery wheel, then thou shalt use a hood over the wheel and goggles over thine eyes that thou bring not blindness upon thine house because of dust entering the windows of thy soul."

The National Safety Council estimates there is one worker killed every fifteen minutes, day and night, in the United States, and one injured every sixteen seconds, day and night. This gives us more than 30,000 killed and about 2,000,000 injured. It is estimated that out of this number there are 200,000 eye injuries. . . .

From an Article on "A Plea for a Complete Urological Diagnosis at One Sitting" (Preliminary Communication), by Martin Krotoszyner, M. D., and George W. Hartman, M. D., San Francisco.—In a recent comprehensive treatise,

(Continued on Back Advertising Section, Page 32)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA[†]

By F. N. SCATENA, M. D.
Secretary-Treasurer

Board Proceedings

A regular meeting of the Board of Medical Examiners was held in San Francisco, June 28 to July 1, 1943, at which time written examinations were conducted for physicians and surgeons, drugless practitioners, and chiropodists. One hundred and thirteen physicians and surgeons, one drugless practitioner, and five chiropodists presented themselves for examination at this meeting.

Legal hearings were conducted by the Board on charges of unprofessional conduct. The following changes were made in the status of licentiates:

Atkinson, John Ames, D. P. (Alleged violation of probation.) On June 30, 1943, Doctor Atkinson was placed on probation for five years, with suspension of license ordered to take effect for one year from July 10, 1943, or if court action taken, then suspension to start ten days after the date of termination of such court action.

Glaeser, William E., M. D. (Alleged illegal operation.) On June 29, 1943, found guilty and license revoked.

Koerber, Lillie Louise, M. D. (Alleged illegal operation.) On June 30, 1943, found guilty and license revoked. Doctor Koerber was granted a stay of execution to and including July 10, 1943.

Weaver, Darrington, M. D. (Record of conviction.) On June 28, 1943, found guilty and his certificate revoked.

The regular meeting of the Board of Medical Examiners was held at the Elks Club, Los Angeles, August 9 to 12, 1943, at which written examinations, legal hearings, and other administrative business were conducted.

News

"Drugless practitioners may legally sign death certificates, according to an opinion released today by Attorney-General Robert W. Kenny. Kenny's opinion was given to the Board of Medical Examiners. Kenny pointed out that the courts of this State had never ruled on the legality of the question. 'In thus making it possible for the drugless practitioner to sign death certificates,' Kenny wrote, 'it should of course be realized that the implication is not to be conveyed that such drugless practitioners may call themselves or advertise themselves as "physicians," or that they may practice "medicine." A drugless practitioner receives his license from the Board of Medical Examiners,' wrote Kenny. 'By law, the mode of treatment of human diseases, injuries and deformities employed by drugless practitioners is recognized. It is difficult for me to believe,' Kenny stated, 'that a drugless practitioner in attendance on such a patient should not be qualified to file the certificate of death as well as the medical certificate.' " (Chico *Enterprise*, June 23, 1943.)

"Attorney-General Robert W. Kenny declared today in an opinion to the State Board of Medical Examiners that the law which prohibits wholesale manufacturers or distributors of lenses and optical supplies from acting as dispensing opticians or optometrists to be unconstitutional on the ground that it is discriminatory. (San Francisco *Call-Bulletin*, June 30, 1943.)

(Continued in Back Advertising Section, Page 45)

[†] This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

[†] The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.

Okay, Doctor—

You Be the Judge!

TO DOCTORS who say "All evaporated milks are alike," our answer is: "Compare the flavor of *all* evaporated milks—then *you* be the judge!"

For flavor is the all-important factor in judging the quality of dairy products. That is why we ask you to taste Special Morning Milk in comparison with all other brands.

Special Morning Milk is fortified with White's vitamin A and D concentrate from the natural source—400 U.S.P. units vitamin D, and 2000 U.S.P. units vitamin A added per reconstituted quart.

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GOOD FOR YOU AND BABY TOO
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Careful selection of raw milk from Western America's finest dairy herds assures fine flavor, high quality of Special Morning Milk.

Scientific laboratory control of milk in processing insures uniformity of flavor, texture, color and quality of Special Morning Milk.

Special MORNING MILK

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Milk
Skimko
EVAPORATED SKIM MILK

Regular Morning Milk and Skimko

together with Special Morning Milk provide the doctor with a high degree of flexibility in meeting infant feeding problems.

For Acidity and Allied Conditions, we suggest

ADAMS SPRINGS MINERAL WATER

● MANY physicians recommend the water in conjunction with the treatment of stomach, liver and kidney trouble.

ADAMS MINERAL SPRINGS is one of the seven known iron and maganese bi-carbonate springs in the world, and the only one in Western America.

It is not a cure-all, but it overcomes acid excesses in the body, and is a very mild but wonderfully effective eliminator. The bowels function without spasm, the kidney output is greatly increased, and there is *marked* drainage of bile from the gall bladder and liver.

There is also some constitutional upset for a few days, particularly in gall bladder cases. But this is soon over and your patient begins to show improvement and is now in condition to profit by any medication you may prescribe. If the case is an operative one, you have improved your patient and made of him a better risk.

We will be pleased to cooperate in any way whatever, and samples of water are yours for the asking.

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SODIUM	365.0 parts per million
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PHOSPHATE	.7 parts per million
CARBONATE	1551.4 parts per million
TOTAL	2591.4 parts per million

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APPROVED BY AMERICAN COLLEGE OF SURGEONS

BOOK REVIEWS

(Continued from Front Advertising Section, Page 24)

Pain Mechanisms. A Physiologic Interpretation of Causalgia and Its Related States. By W. K. Livingston, Lieutenant Commander, M. C., U. S. N. R.; Assistant Clinical Professor of Surgery, University of Oregon Medical School, Portland, Oregon. Cloth. Price $3.75. Pp. 253, with illustrations. New York: The Macmillan Company, 1943.

As stated by the author, his monograph on pain mechanisms has been written many times. He takes up the tremendous complexity of the problems relating to pain and all sensory perceptions.

The author has endeavored to present his observations and interpretations in a personal and direct manner, as nearly as possible like a person-to-person conversation, or a lecture to a class of medical students. He emphasizes the value of the original work of Weir Mitchell, which he stated was not read until after working for several years with the Oregon State Industrial Accident Commission, and as neurosurgic consultant for the Portland Facility of the Veterans' Administration, and at a time when a considerable portion of his practice was devoted to the study and treatment of pain syndromes.

He expresses the hope that after reading the monograph, a physician may acquire a more sympathetic understanding of the sufferings of a patient with an irritative nerve lesion.

First Aid Surgical and Medical. By Warren H. Cole, M. D., F. A. C. S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Director of Surgical Service, Illinois Research and Educational Hospitals, Chicago; and Lieutenant Colonel Charles B. Puestow, Medical Corps, Army of the United States. Second Edition. Cloth. Price $3.00. Pp. 351, with illustrations by Carl Linden in collaboration with Tom Jones of the Illustration Studios of the University of Illinois College of Medicine, Chicago. New York, London: D. Appleton-Century Company, Incorporated, 1943.

No one disputes the fact that First Aid should be reserved for physicians whenever they are available; yet it is obvious that until a physician arrives, very helpful aid, which may even be life-saving, may be rendered by trained. nonmedical personnel. The authors state that they have attempted to make the text sufficiently scientific and practical to be of value to physicians who desire information on First Aid. It should be of value to nurses, all of whom are expected to be familiar with First Aid procedures. The authors have also endeavored to compile material that will be particularly adaptable to the teaching of medical students or students with similar scientific training.

It has been well stated that the utilization of First Aid has become very important during the past few decades because of marked industrial development and tremendous increase in automobile accidents, yet the need obviously is much greater in times of war. Subjects such as Wounds, Burns, Hemorrhage and Shock are taken up in considerable detail. In general, when dealing with emergencies of the military type, the authors have stressed treatment which is being adopted by the American Armed Forces in the present war.

A Guide to Practical Nutrition. A series of articles on nutrition, sponsored by the Committee on Nutrition and Deficiency Diseases of The Philadelphia County Medical Society. Edited for the Committee by Michael G. Wohl, M. D., and John H. Willard, M. D. Introduction by Morris Fishbein, M. D., Editor, Journal of the American Medical Association. Reprinted from "Philadelphia Medicine," 1941-1942. Paper. Pp. 98. Philadelphia: The Philadelphia County Medical Society, 1943.

(Continued on Page 30)

Such language!

My boss used to be as grumpy as a bear. He'd growl and bang around and his wife said: "Poor George, he's working too hard. It's wearing him down to a frazzle!"

So, I told her a few plain facts:

> . . . how I'd discovered the most amazing thing . . . that physicians who prescribe S-M-A* actually have more time for other things . . . because it isn't necessary to change the formula throughout the entire feeding period. (She sat up at that.)
>
> . . . how S-M-A eliminates many unnecessary questions that mothers usually ask about other modified milk formulas.

When I had finished, she said she would certainly speak to George about using S-M-A as a routine formula.

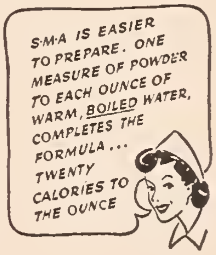
* * *

Just because my boss turned over a new leaf . . . he wants everybody to pat him on the back for it. But he's not fooling us . . . we know how he got to be such a nice man.

BUSY DOCTORS TODAY—PRESCRIBE S-M-A!

With the exception of Vitamin C . . . S-M-A is nutritionally complete. Vitamins B_1, D and A are included in adequate proportion . . . ready to feed. Their presence in S-M-A prevents the development of subclinical vitamin deficiencies . . . because the infant gets all the necessary vitamins right from the start.

S-M-A has still another highly important advantage not found in other modified milk formulas. It contains a special fat that resembles breast milk fat . . . resembles it chemically and physically—according to impartial laboratory tests. S-M-A fat is more readily digested and tolerated by most infants than cow's milk fat.


S-M-A IS EASIER TO PREPARE. ONE MEASURE OF POWDER TO EACH OUNCE OF WARM, BOILED WATER, COMPLETES THE FORMULA . . . TWENTY CALORIES TO THE OUNCE

The infant food that is nutritionally complete

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S-M-A, a trade-mark of S.M.A. Corporation, for its brand of food especially prepared for infant feeding—derived from tuberculin-tested cow's milk, the fat of which is replaced by animal and vegetable fats, including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and physical properties.

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CONTHEX solution presents all of the known factors of the B complex group, in a stable, highly concentrated form, which is miscible with water, milk or fruit juices.

CONTHEX is prepared from an extract of rice bran concentrate, to which have been added some pure, crystalline synthetic materials.

CONTHEX is indicated for a supplementary use, in the treatment and prophylaxis of B complex deficiencies, and offers, as one of its principal advantages, the elimination of the unpleasantness of syrups and like forms, with the added assurance of supplying sufficient quantities of the various factors.

•

CONTHEX, presents, per one cc.:

Thiamine HCl	15 mgm.
Riboflavin	500 gamma
Pyridoxine HCl	250 gamma
Calc. Pantothenate	250 gamma
Niacinamide	10 mgm.
Alcohol	5 %
Ac. Benzoic	.1 %

•

Available in thirty (30) cc. dropper bottles.

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ITEM No. 162

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* *In Military Service*

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Rates to Fit Any Budget

Near Chico,
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California

For particulars, write

LEE RICHARDSON, RICHARDSON SPRINGS, CALIFORNIA

BOOK REVIEWS

(Continued from Page 28)

This book comes from the Committee on Nutrition and Deficiency Diseases of The Philadelphia County Medical Society and is presented to the medical profession in order to increase the practicing physician's interest in the new knowledge of nutrition. They trust that in doing so they may, to a degree, succeed in educating the physician to the importance of educating the public to the importance of proper nutrition as a means to improved health.

It is well stated therein that education in nutrition, then, must be supervised by medical authority. So far at least as nutrition is concerned, the physician must become aware of his duties in the fostering of public health, just as he is already aware of his duties in the fostering of private health. He must consider himself a public health officer in his community: the community as a whole must be a patient of his as well as this member of it or that.

The plea is made that public health measures must always begin as private health measures: typhoid fever, diphtheria, smallpox—these, once matters of private practice, are now the concern of the various Boards of Public Health; should not nutrition eventually be their concern also?

The contributors have produced an excellent presentation of this subject, that is of increasing importance under existing conditions.

Essentials of Industrial Health. By C. O. Sappington, M. D., Dr. P. H., Consulting Industrial Hygienist, President, Central States Society of Industrial Medicine and Surgery, Editor of "Industrial Medicine." Cloth. Price $6.50. Pp.

(Continued on Page 32)

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BEER

ACME BREWERIES
San Francisco • Los Angeles

BOOK REVIEWS

(Continued from Page 30)

626, with 63 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

The author calls attention to how vast a contribution could be made to the war efforts by well-organized industrial-health programs. A reduction of 10 per cent in the 400,000,000 man-days now lost annually from illness and injury in industry represents the time required to build five capital ships, 16,000 tanks, or 9,000 bombers.

It is also stated that the health of the industrial worker has always been an important bulwark of production in peacetime, but in the prosecution of mechanized warfare it becomes the proving-ground for the success of the combatant forces. The war can and will be won on industrial assembly lines.

As indicated by the author, no industry can proceed at full speed unless its individual human units have a fair degree of the personal (physical and mental) health so vital to the quantity, quality, and continuity of production. One skilled worker absent because of preventable illness can greatly disturb the smooth functioning of the production line and cause losses out of all proportion to expectation, because of the disruption of teamwork.

The book represents the application of preventive medicine and public health to industry. The author believes that the next great advances in public health will be made in industry. He states further that this approach will be made through industrial case-finding, thus bringing about early diagnosis, supervision, and treatment with the coöperation of the family physician, and will thus be of tremendous importance in the rapid restoration of the human unit to a self-sustaining basis.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 154)

dealing with the "comparative result of various functional kidney tests," a table is presented containing, in historical sequence, a fairly complete list of the many tests that have been devised for determination of renal function, the majority of which were introduced during the last fifteen or twenty years, or since the dawn of the era of scientific urology. As a result of this overproduction of renal tests, which were thrust upon the profession so frequently and at such short intervals as to prevent the average clinician familiarizing himself with their meritorious or objectionable features, a deplorable lack of uniformity has developed among urologists in various parts of the world as regards the estimation of the clinical value and preferential application of these tests. . . .

From an Article on "The Prevention of Congenital Syphilis by Antiluetic Prenatal Therapy," by H. Lisser, A. B., M. D., San Francisco.—At a time when literally millions of able-bodied men are being slaughtered throughout the world and, consequently, repopulation of the largest and most important civilized communities is a very imminent and overwhelmingly important problem, any measure that even in some small degree may lead to the hope of ensuring birth to numberless fetuses that would otherwise miscarry or be born dead at term, and that to some extent would ensure a greater length of life *after* birth to those born alive, becomes at once a subject of more than mere scientific interest. . . .

From an Article on "Results Following Operative Treatment of Pelvic Inflammatory Disease in the Stanford University Clinic," by John A. Sperry, San Francisco.—The

(Continued on Page 34)

EDEMA DURATION

due to the varying methods of cigarette manufacture

(as shown by rabbit-eye test)*

Upon instillation of smoke solution from PHILIP MORRIS Cigarettes

Average duration
8 MINUTES

Upon instillation of smoke solution from cigarettes made by the *Ordinary Method*

Average duration
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**Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245* ***Laryngoscope, 1935, XLV, No. 2, 149-154*

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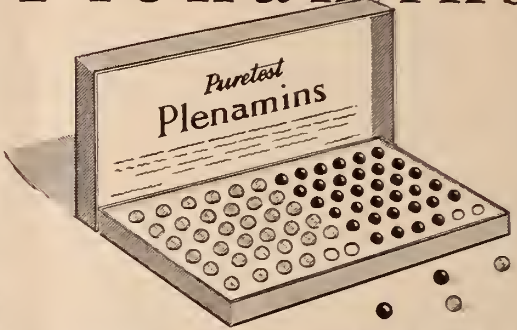

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Glenroy N. Pierce, M.D., San Francisco
Ina Gourley, M.D., Oakland

TWENTY-FIVE YEARS AGO

(Continued from Page 32)

subject of pelvic inflammatory disease has been written about since the year 1500 B. C. There are very few meetings of gynecologists or obstetricians at which this subject is not touched upon in some major or minor way.

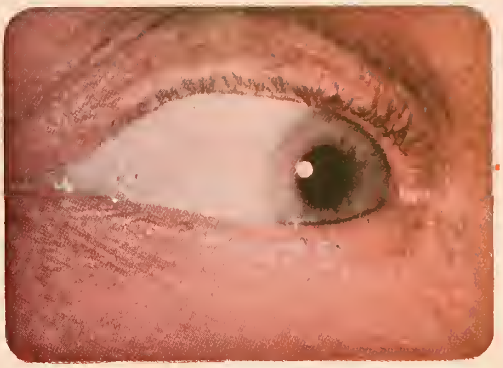
I fear that further discussion may be considered trite and commonplace. However, inasmuch as the statistics I have gathered show that we, in our clinic, at least are very far from having found what may be considered an entirely satisfactory method of dealing with these cases, it will do no harm to point out some of the weak and strong points that have been shown in the collection of statistics, to be quoted in this paper. . . .

From an Article on "Training of Fixation and Fusion in Strabismus," by Kaspar Pischel, M.D., San Francisco.—First of all, I must confess that I have nothing new to offer. As an excuse for bringing before you facts which you all know, accept the observation that we sometimes, in the nervous search for new things, overlook old, reliable methods. Especially is this true when our attention is attracted by new operative procedures. I will not read a long paper: I will only exemplify the short statement of the synopsis by the history of a few cases.

Training will often prevent latent strabismus from becoming manifest and may obviate an operation in manifest strabismus. If an operation is found necessary, better results will be insured by the improvement of the sight of the squinting eye and by the increase of the fusion power. . . .

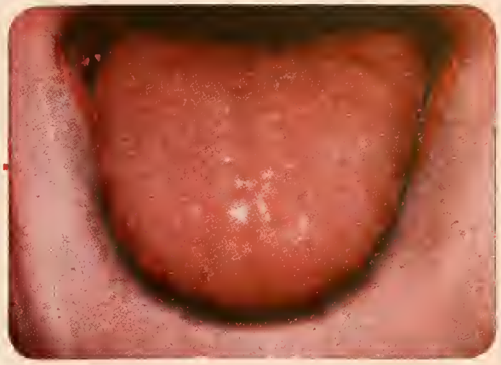
(Continued on Page 36)

THE PHYSICIAN ALONE



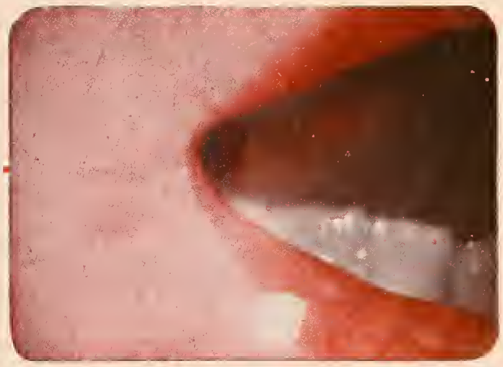
Early sign of Vitamin A Deficiency: slight thickening of conjunctiva at equator; slight increase of vascularity; swelling of caruncle and plica semilunaris.

IS QUALIFIED



Early Indication of B Complex Deficiency Shown in Marginal "Fluting" of Tongue with Redness or Soreness of Tip.

TO INTERPRET



Early Manifestation of Ariboflavinosis is Found in Pallor and Maceration of Lips at Angles of Mouth.

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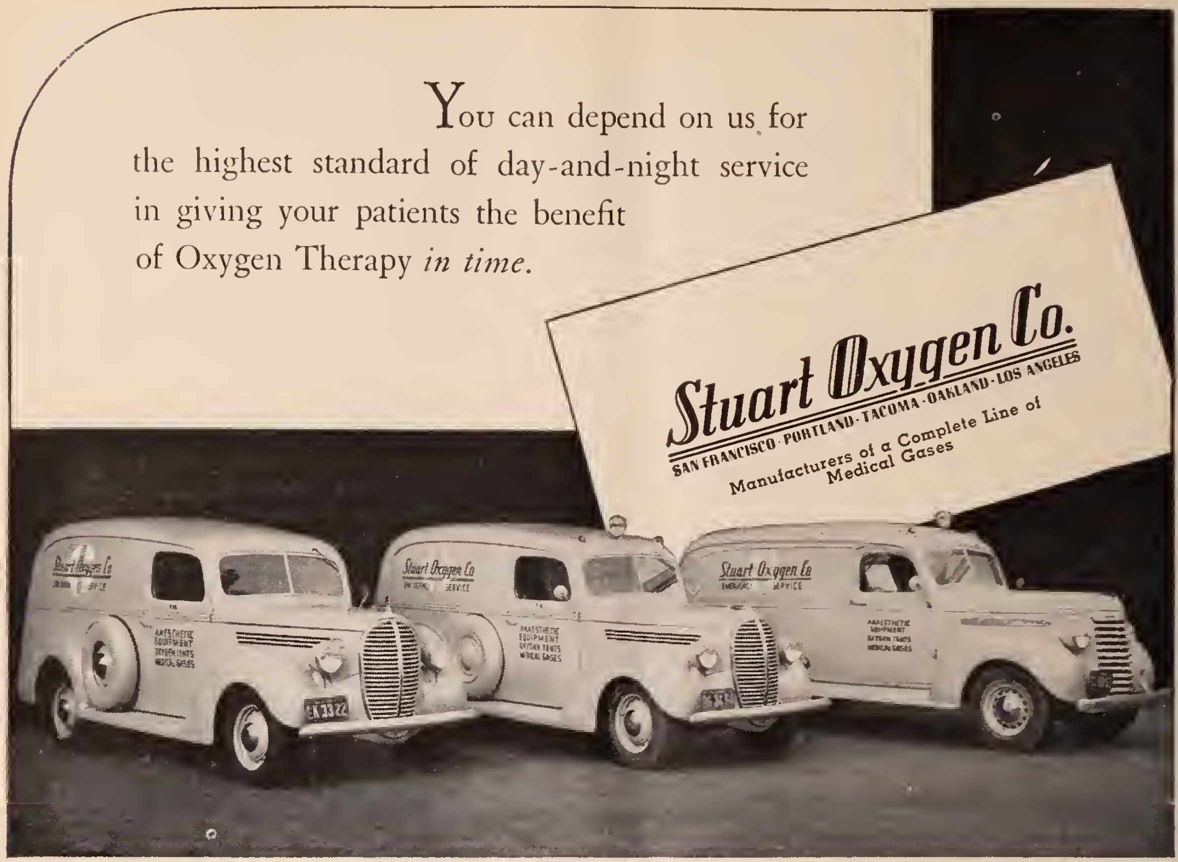
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TWENTY-FIVE YEARS AGO

(Continued from Page 34)

Excerpts from Military News: Army Health.—Secretary Baker has given out the following information:

Health of Men in Cantonments: The deaths per thousand, from all causes, in the Regular Army of the United States has been as follows:

1898	20.14
1900	7.78
1901	6.90
1916	5.13

The death rate per thousand among all troops—Regulars, National Army, and National Guard—in the United States for the week ending May 31 was 4.89, and for the week ending June 7, 4.14. The death rate for disease only among all troops in the United States for week ending June 7 was 3.16, which is still lower than that of the preceding week (3.2), then the record low rate since that of November 2, 1917.

The bed capacity on June 5 in all department hospitals in the United States was 72,667. New construction now under way will provide for a total of 87,344 beds. The number of base and general hospitals in this country has increased from 7 to 72, and will be further increased. Vast hospital facilities have been organized and are being organized in France, providing beds numbering from 5 per cent to 10 per cent of the number of men in the American Expeditionary Forces.

Psychological examinations, of which more than 500,000 have been made, result in the weeding out of about one-fourth of one per cent of the men examined.

Nutritional surveys in 270 messes in fifty camps have resulted in a readjustment of rations and a conservation of food.

The number of officers in the Medical Corps has increased from 900 to 24,000; the number of enlisted men from 8,000 to 148,000. These figures, of course, are exclusive of the Sanitary Corps and of the Army nurses.

Guarding Camps from Flies and Mosquitoes.—To guard troops stationed in camps and cantonments from disease carried by mosquitoes and flies, the medical department of the Army has installed a system of prevention which is safeguarding not only the soldiers, but also civilians living in the neighborhood of training camps.

There is attached to each camp a division surgeon who is responsible for the health of the camp. Assisting him is a sanitary inspector who has the assistance of a sanitary engineer, and from 100 to 200 enlisted men who are continually employed in work designed to protect the health of the soldiers. . . .

Excerpts from Examinations for Medical License, June, 1918, San Francisco.

* * *

Chemistry and Toxicology—Physicians and Surgeons

H. E. Alderson, M. D.

(Answer Ten Questions Only)

1. Discuss the chemical changes that occur when a strong aqueous solution of $Ag\ No_3$ is applied to a mucus patch.

(Continued on Page 40)

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Bequest Forms:
Unto the Physicians' Benevolence Fund of the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $——— for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $———, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be paid to and become a part of the Physicians' Benevolence Fund of the California Medical Association as said fund is established and maintained by said Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I hereby give and bequeath unto the Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be expended by said corporation for the benefit and as a part of the Physicians' Benevolence Fund of the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California, for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association the following described real property situate in the county of ——— State of California, and more particularly described as follows, to-wit:

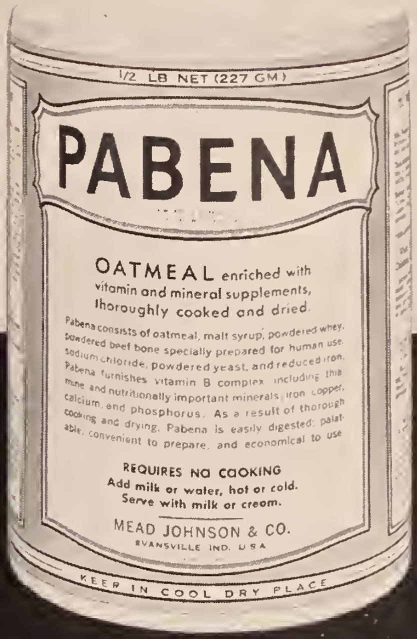
* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be held as a part of the Physicians' Benevolence Fund of the California Medical Association, the income whereof shall be used for the purposes of said fund as it is established and maintained by the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

---

* Correspondence for the Physicians' Benevolence Committee may be addressed to the C. M. A. office or to Axcel E. Anderson, Chairman, 1759 Fulton Street, Fresno.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OATMEAL enriched with vitamin and mineral supplements, thoroughly cooked and dried.
Pabena consists of oatmeal, malt syrup, powdered whey, powdered beef bone specially prepared for human use, sodium chloride, powdered yeast, and reduced iron. Pabena furnishes vitamin B complex including thiamine and nutritionally important minerals, iron, copper, calcium, and phosphorus. As a result of thorough cooking and drying, Pabena is easily digested; palatable, convenient to prepare, and economical to use
REQUIRES NO COOKING
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Serve with milk or cream.
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TWENTY-FIVE YEARS AGO

(Continued from Page 36)

2. Discuss the properties of sulphur praecipitate.
3. Discuss chronic silver nitrate poisoning.
4. In what strength should aqueous solution of mercury biniodide contain potassium iodide? Why?
5. Discuss the probable toxic agent responsible for the following symptoms: nausea, frontal headache, coryza, salivation, bad taste, and a pustular eruption.
6. Discuss the probable toxic agent responsible for the following symptoms: coryza, reddened conjunctiva, puffy eyelids, pigmentation, hyperkeratosis, cramps, and diarrhea.
7. Which is a more dangerous poison, strychnine or carbolic acid? Why?
8. Discuss "lye" poisoning and the antidotes.
9. What is the result of heating a mixture of HNO_2 and $KCLO_3$?
10. In what cases of poisoning should emetics not be given? Why?
11. Discuss atropine poisoning.
12. Describe sodium and discuss three of its salts. . . .

* * *

Surgery—Physicians and Surgeons

William R. Molony, M. D.

(Answer Ten Questions Only)

1. Briefly discuss traumatic shock and in particular its diagnosis.
2. A woman sixty years of age, as the result of an automobile accident, sustains a fracture of the left femur in the middle, compound fracture of the left humerus in the middle, and a fracture of both bones of the left forearm. In addition to the above, she is in profound shock. Give management of case during the first week.
3. In the above case, at the end of the first week, the skin of the entire left forearm shows dry gangrene. Give management of entire case from end of first week to final conclusion.
4. Give technique of any approved operation for the cure of prolapsus uteri (incomplete) in a woman past the menopause.
5. What pathological conditions of the blood may modify or interfere with normal tissue repair?
6. Give the technique of an operation for decompression in the subtemporal region.
7. Give management of abscess (unbroken) of vulvovaginal gland.
8. What symptoms, signs, and laboratory findings determine the necessity for immediate operation for appendicitis?
9. Stricture of the oesophagus in any part; etiology, symptoms, and differential diagnosis.
10. A patient presents himself with a hard indurated nonulcerative tumor, the size of a pea, on the margin of the tongue. Give management of the case.
11. Give three accepted routes for drainage of maxillary sinus (antrum of Highmore). Give technique of one operation.
12. Discuss treatment of uterine fibroid other than surgical.

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A Wetting Agent
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Emollient Effect
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*Hirsch, M. M., and Novak, M. V.: Evaluation of Germicides with Relation to Tissue Toxicity. Proc. Soc. Exper. Biol. and Med., June, 1942.

ZEPHIRAN CHLORIDE . . . Germicide for Surgery, Obstetrics and Gynecology, Urology, Dermatology, Eye, Ear, Nose and Throat, Sterile Storage of Instruments.

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Penicillin.—Winthrop Chemical Company, Inc., today announced plans for a "vast increase" in production of penicillin, new highly concentrated extract from common cheese mold which kills bacteria and which has proved to be rapidly curative in such diseases as blood stream infection, osteomyelitis, pneumonia and gonorrhea.

Additional facilities for the manufacture of this potent drug have been acquired in Rensselaer, N. Y., according to Dr. Theodore G. Klumpp, President, and will be devoted entirely to the manufacture of the drug which is now allocated exclusively to the armed forces. The War Production Board has granted high priority ratings for needed equipment, he said, and work is proceeding at all possible speed.

"We are preparing now for the day when penicillin will become available to all who need it," Doctor Klumpp declared.

The "unit" system of measurement derives from Oxford University, where outstanding important basic contributions to our understanding of the value of the drug were made. Pure penicillin has not yet been isolated, and the "Oxford Unit" is based upon comparison with standard material furnished by Oxford University to laboratories throughout the world. One million units weigh approximately one-fifth ounce.

Penicillin was discovered by Dr. Alexander Fleming, English scientist, in 1929. Fleming noticed that when an agar plate on which he was growing disease producing bacteria became contaminated with the cheese mold, the germ colonies immediately surrounding the mold were destroyed. He immediately set to work and prepared crude extracts of penicillin which he used in growing some delicate bacteria in the laboratory to prevent their being choked out by hardier, unwanted species, such as staphylococci and streptococci. Penicillin was used in laboratories

(Continued on Page 44)

A complete unit for
Approved
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KOROMEX
H-R Emulsion Cream
HOLLAND-RANTOS COMPANY, INC.
H-R KOROMEX 70

"THE KOROMEX SET COMPLETE"

Koromex Set Complete* is an attractively packaged unit containing the important items used for approved contraceptive technique. Identified by a removable label. To order or prescribe, merely write, "Koromex Set Complete, Diaphragm Size_____".

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PENICILLIN

(Continued from Page 42)

for this purpose for many years. It was not available for treatment of disease, however, because of the extremely small quantities that could be produced, and also because of the instability of the substance. Then Dr. Rene Dubos of the Rockefeller Institute for Medical Research succeeded in producing from soil bacteria a powerful antibacterial substance called gramicidin, and research workers were given impetus to carry out further intensive investigations of penicillin. The present interest in pinicillin dates from 1939.

Penicillin is now under strict allocation of the War Production Board for national defense, and there is no prospect that a surplus will soon be available for civilian use.

Experimental Research Laboratories Appointment.—Dr. Erwin E. Nelson has been appointed Director of Research of the Burroughs Wellcome & Co. (U. S. A.) Experimental Research Laboratories at Tuckahoe, N. Y. For the past six years Doctor Nelson has been Professor and Head of the Department of Pharmacology, Tulane University School of Medicine.

Doctor Nelson is well known for his contributions in the fields of medicine and pharmacology. He was formerly chief of the Division of Pharmacology, Food and Drug Administration and for many years served as consultant to the Food and Drug Administration. He is a member of various scientific committees, including the Revision Committee of the U. S. Pharmacopoeia, and at present is chairman of the Subcommittee on Biological Assays.

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(Continued from Text Page 154)

"The recent announcement of the Office of War Information that 97 per cent of naval and marine personnel wounded from Pearl Harbor to March 31, 1943, have recovered, is a dramatic proof of the excellence with which the Navy Bureau of Medicine and Surgery is functioning. Army figures, not yet completely available, will show the same percentage, according to the OWI, and that is an equal tribute to the Army Medical Department. . . ." (San Francisco *News*, July 5, 1943.)

"Amos F. Clapp and B. W. Goode, chiropractors, who were found guilty of performing an illegal operation by a jury in Superior Court last week, today were sentenced to San Quentin Prison for from two to five years by Superior Judge Stanley Mosk. On motion of Attorney A. H. McConnell, the two men were allowed to remain at liberty on $2,000 bail, pending outcome of an appeal, notice of which was served following sentence. . . ." (Long Beach *Press-Telegram*, June 17, 1943.)

Minutes of the Meeting of the Review Committee of the Board of Medical Examiners

(Continued from Adv. Page 38, July CALIFORNIA AND WESTERN MEDICINE)

NAME	SCHOOL
Tuchman, Leopold Stanley *Los Angeles*	N. Y. Univ. Coll. of Med., '42
Turner, Charles Try *Los Angeles*	U. of So. California Sch. of Med., '43
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Vaughn, Arax Jeanette *Los Angeles*	Creighton U. Sch. of Med., Neb., '42
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Secretary, Carl W. Clark, 1010 B Street, San Rafael.

Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society

President, John H. Lloyd, Fort Bragg.

Secretary, Louise E. Petty, Talmage.

Meeting, *On Call.*

Merced County Medical Society

President, J. J. McNearney, 311 Shaffer Building, Merced.

Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.

Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society

President, Rollin Reeves, 32 E. San Luis Street, Salinas.

Secretary, S. Condit Glasgow, 8 E. Alisal Street, Salinas.

Meeting, *First Thursday.*

Napa County Medical Society

President, I. E. Charlesworth,* Napa State Hospital, Imola.

Secretary, M. M. Booth, Bruck Building, St. Helena.

Meeting, *First Wednesday.*

Orange County Medical Association

President, D. A. Harwood,* 2145 Walnut, Santa Ana.

Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.

Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society

President, Lucas W. Empey, Roseville.

Secretary, Robert A. Peers, Colfax.

Meeting, *At Call of President.*

Riverside County Medical Society

President, Thomas A. Card, 3616 Main Street, Riverside.

Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.

Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement

President, Edward S. Babcock, 1127 Eleventh Street, Sacramento.

Secretary, Carl E. Burkland, 510 Medico-Dental Building, Sacramento.

Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society

President, J. M. O'Donnell, Hollister.

Secretary, L. E. Smith, Hollister.

Meeting, *At Call of President.*

San Bernardino County Medical Society

President, Edward H. Risley, Loma Linda.*

Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.

Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society

President, W. Don Rolph, 640 National Avenue, National City.

Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.

Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society

President, Sidney J. Shipman, 490 Post Street, San Francisco.

Secretary, Chester L. Cooley, 490 Post Street, San Francisco.

Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, Curtis M. Galt, 134 N. Lincoln Avenue, Manteca.

Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.

Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society

President, F. F. Ragsdale, 717 Twelfth Street, Paso Robles.

Secretary, Harrison Eilers, Box 360, San Luis Obispo.

Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society

President, William A. Key, 23 Second Avenue, San Mateo.

Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.

Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society

President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.

Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.

Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association

President, J. Irving Beattie,* 652 E. Santa Clara Street, San Jose.

Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society

President, F. P. Shenk, Medico-Dental Building, Santa Cruz.

Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.

Meetings: *February, April, October, and December. Time and place to be decided by the President*

Shasta County Medical Society

President, Oscar Jess Hansen, 1726 Market Street, Redding.

Secretary, John E. Kirkpatrick, Shasta Dam.

Meeting, *Second Monday.*

Siskiyou County Medical Society

President, H. L. Vidricksen, Weed Hospital, Weed.

Secretary, F. W. Martin, Mt. Shasta.

Meeting, *Sunday on Call.*

Solano County Medical Society

President, Cary A. Snoddy, 405 Georgia Street, Vallejo.

Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.

Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society

President, Clifford M. Carlson, 576 B Street, Santa Rosa.

Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.

Meeting, *Second Thursday.*

Stanislaus County Medical Society

President, Terry T. Laird, 107 Crescent Road, San Anselmo.

Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.

Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society

President, Frank L. Doane, Red Bluff.

Secretary, R. G. Frey, Red Bluff.

Meeting, *At Call of President.*

Tulare County Medical Society

President, Karl F. Weiss, 222 West Willow Street, Visalia.

Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society

President, G. C. Coffey, Bank of America Building, Ventura.

Secretary, M. M. Raines, 34 North Ash Street, Ventura.

Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society

President, Ray E. Nichols, Woodland.

Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.

Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society

President, John W. Lindstrum, 423 Fourth Street, Marysville.

Secretary, Joseph J. Salopek, 423 Fourth Street, Marysville.

Meeting, *Second Wednesday.*

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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco. Phone WEst 8000.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles. Phone Fitzroy 7694.

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* Auxiliaries not heard from as yet this year.

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San Francisco—603 Phelan Building, 760 Market Street, San Francisco; UNderhill 8700.

Sacramento—631 J Street.

Los Angeles — State Office Building, 217 West First Street, MAdison 1281.

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Director, Wilton L. Halverson, 603 Phelan Building, 760 Market Street, San Francisco.

California Northern District Medical Society

President, John H. White, Chico.
Secretary, J. Homer Woolsey, Woodland Clinic, Woodland.

Board of Medical Examiners of the State of California

San Francisco—Room 214, 515 Van Ness Avenue.

Los Angeles—906 State Building.

Sacramento — Business and Professional Building, 1020 N Street.

Secretary, Frederick N. Scatena, M. D., 1127 Eleventh Street, Sacramento.

Southern California Medical Association

President, Ray B. McCarty, 3116 Main Street, Riverside.

Secretary, Nelson Paul Anderson, 2007 Wilshire Boulevard, Los Angeles.

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Executive Secretary, Ben H. Read, San Francisco office, 251 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 5711.

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Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean.
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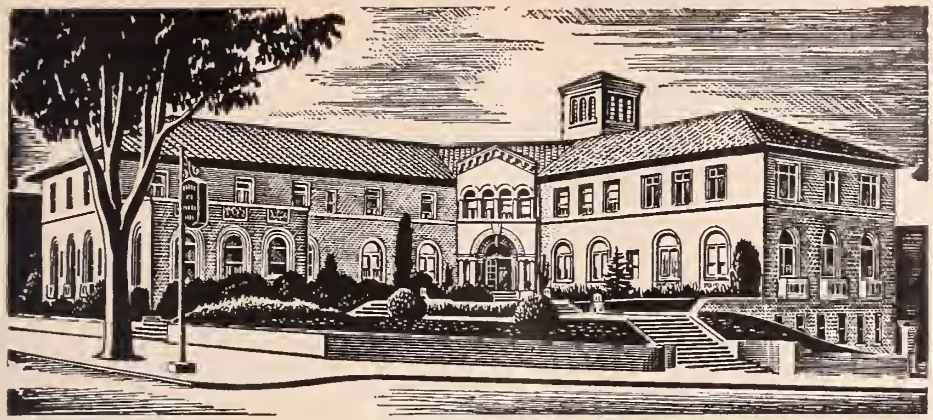

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BOOKS RECEIVED

Kaiser Wakes the Doctors. By Paul De Kruif. Cloth. Price, $2. Pp. 158. New York: Harcourt, Brace & Company, 1943.

Applied Anatomy of the Head and Neck. For Students and Practitioners of Dentistry. By Harry H. Shapiro, D. M. D., Assistant Professor of Anatomy, College of Physicians and Surgeons, Columbia University. Cloth. Price, $5.50. Pp. 189, with 173 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

Reconstructive Surgery of the Eyelids. By Wendell L. Hughes, M. D., F. A. C. S., Hempstead, New York. Cloth. Pp. 160, with illustrations. St. Louis: The C. V. Mosby Company, 1943.

BOOK REVIEWS

The Eye Manifestations of Internal Diseases. By I. S. Tassman, M. D., Associate Professor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania, Philadelphia; Attending Surgeon, Wills Hospital, Philadelphia. Cloth. Pp. 542, with 201 illustrations including 19 in color. St. Louis: The C. V. Mosby Company, 1942.

This text is based on the author's lectures on medical ophthalmology given at the Graduate School of Medicine, University of Pennsylvania. The presentation aims "to bridge any existing gap between the eye manifestations and the other medical aspects of the internal diseases." The author's comprehensive scope is indicated at the start by a systematic and detailed table of contents. The treatment,

(Continued on Page 10)

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(Continued from Page 7)

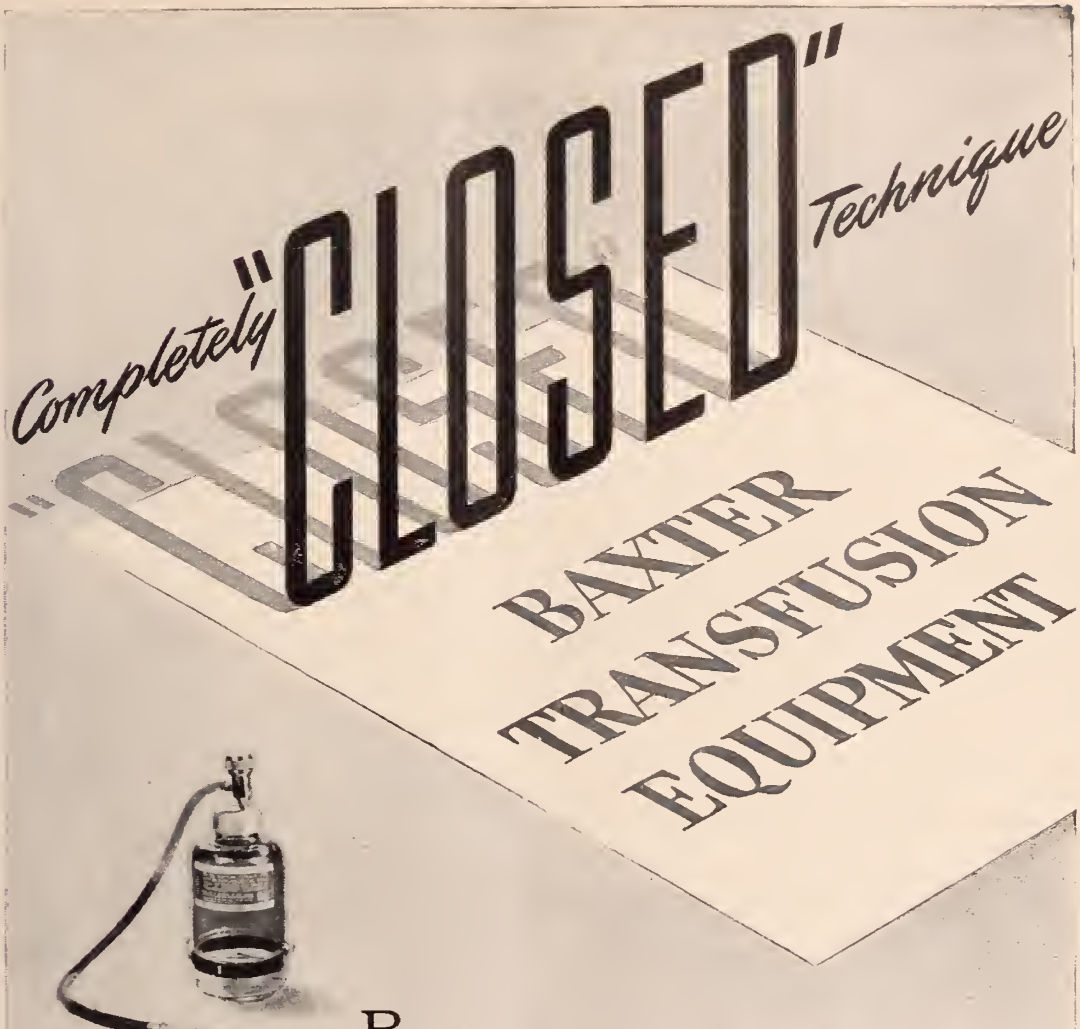
though elementary, is authoritative and adequate for orientation. Each chapter concludes with a selected bibliography of recent literature which should aid the reader interested in a more exhaustive discussion of a particular subject. The illustrations are clear, ample, and well selected.

J. E. L.

Orbital Tumors. Results Following the Transcranial Operative Attack. By Walter E. Dandy, Adjunct Professor, Neurological Surgery, Johns Hopkins University. Cloth. Price, $5. Pp. 168, with 100 illustrations. New York: Oskar Piest, 1941.

Orbital tumors are surgically separable into two very unequal divisions. Only the lesser group belongs to the ophthalmologist, and to be included therein the tumor must be limited to the anterior portion of the orbit and accessible for removal through the conjunctiva or upper lid, and, of paramount importance, the absence of intracranial extension must be definitely established. Unfortunately, most orbital tumors are deeply situated, and secondary to an intracranial nidus, or involved in intracranial extension, this complication being the cause of death in 75 per cent of the cases coming to necropsy. The neurosurgical technique developed in the hypophyseal approach permits the removal of the combined orbital and intracranial growths at the same operation. The optic nerve, the eyeball, and the muscles and vessels of the orbit are well exposed and avoided during the dissection of the orbital tumor, and hence the tumor is removed more safely and more radically than was ever possible in the Krönlein procedure or in orbital exenteration. Not only does the transcranial operation offer the maximum hope of cure, but it involves little

(Continued on Page 14)



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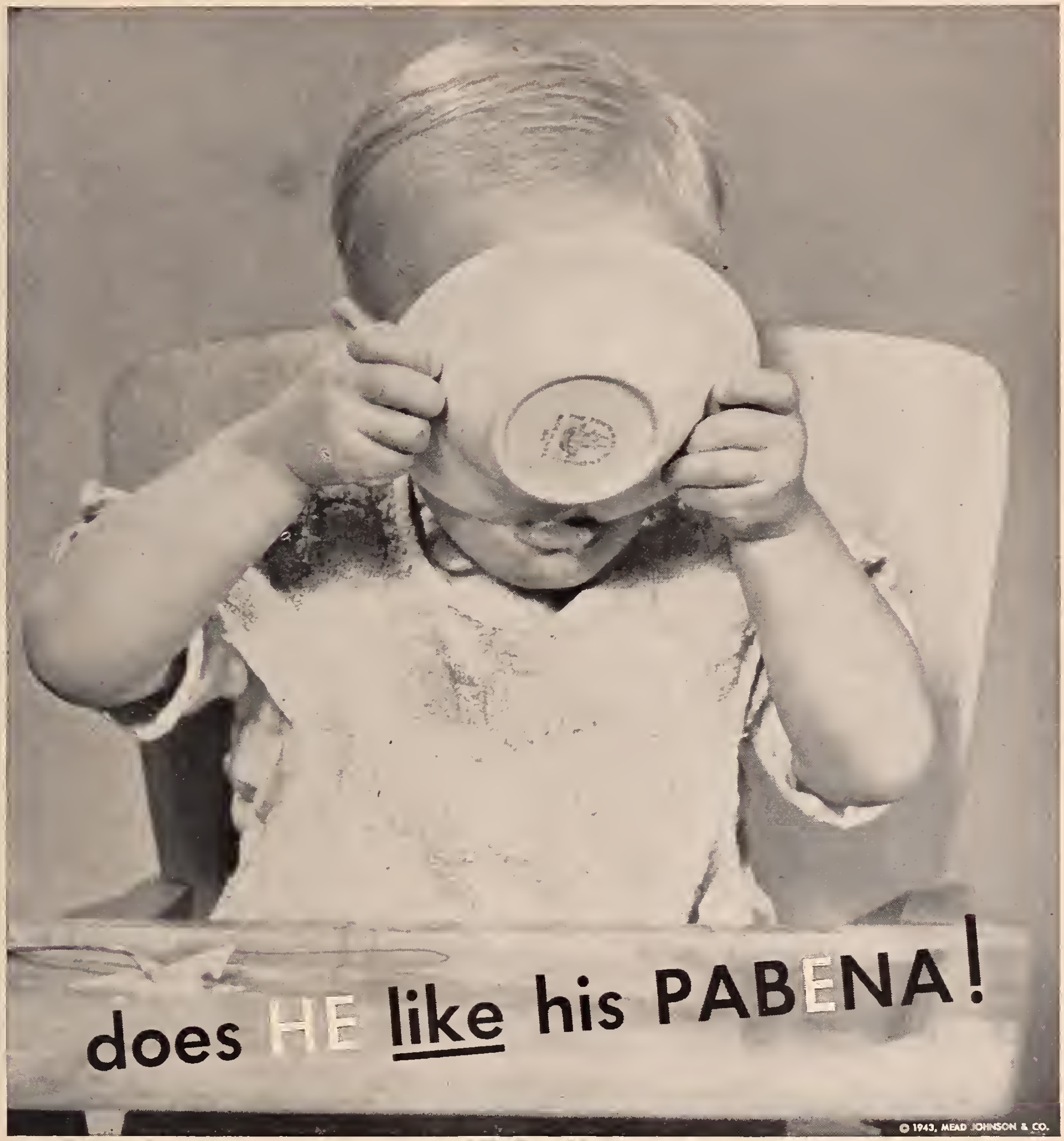
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BOOK REVIEWS

(Continued from Page 10)

risk and rarely results in any cosmetic deformity. The contraindication to the operation is a prior enucleation or orbital exenteration because of the danger of infection then present.

Dandy originated this approach in 1922, and since then has encountered thirty-one patients with orbital tumor, on twenty-four of which he operated. The cases are discussed in detail in this monograph, and include nine with dural meningioma and hyperostosis of skull, five with Schüller-Christian disease, four with glioma, two with dural tumors, two with osteomatous cyst, and one each with inflammatory mass, fibroma, osteoma, spindle-cell sarcoma, round-cell sarcoma, meningioma of nerve sheath, sarcoma with hyperostosis of skull, periosteal sarcoma, and carcinoma. Significantly only six of these tumors, or 20 per cent, were confined solely to the orbit.

J. E. L.

Mental Illness: A Guide for the Family. By Edith M. Stern, with the collaboration of Samuel W. Hamilton, M. D. Cloth. Price, $1. Pp. 134. New York: The Commonwealth Fund, 1942.

"Mental Illness: A Guide for the Family" is an accurate description of this excellently done little book. Miss Stern first removes the stigma from the condition of mental illness in the minds of her readers. She then describes, in logical fashion, the handling of the individual case. She stresses the importance of recognition of the illness and the reasons for hospitalization; she explains the procedure of admittance to the hospital; she describes what the hospital seeks to accomplish and how; and she discusses the difficulties of readjustment to home conditions upon discharge from the hospital. A spirit of sympathetic understanding of both the patient and his family pervades the book. In recommending this little book to the families of his mentally ill patients, the physician will be helping himself as well as his patients.

F. G. LINDEMULDER, M. D.

Outline of Roentgen Diagnosis. An Orientation in the Basic Principles of Diagnosis by the Roentgen Method. By Leo G. Rigler, B. S., M. B., M. D., Professor of Radiology, University of Minnesota, Minneapolis. Second Edition. Cloth. Price, $6.50. Pp. 196, with 254 illustrations shown in 227 figures, presented in drawings and reproductions of roentgenograms; figures 6 to 51 and 55 to 72 being drawings in an original technique by Jean E. Hirsch. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

The second edition of this outline finds many additions and improvements, while the reproductions and drawings remain excellent. The purpose of this book, as stated by the author, is admirably served, and it should prove valuable for the teacher and undergraduate student as an adjunct to illustrative lectures. Without associated lectures, however, to demonstrate and correlate roentgen findings with pathology and physiology, the book is of limited value.

Diet in Sinus Infections and Colds. By Egon V. Ullmann, M. D. Second Edition. Cloth. Price, $2. Pp. 185. New York: The Macmillan Company, 1941.

The problem of how best to treat patients who suffer from sinus trouble and repeated colds has been much debated. The author states that the past decade, though, has brought the wave of an almost universal surgical approach to these cases to a remarkable retardation.

He contends that living habits, constitutional defects, inherited qualities, a deficiency of vitamins and a false diet are perhaps more often to be blamed for repeated colds and sinus trouble than bacteria.

He believes that a diet which is designed to counteract many of these defects must be regarded as a logical and

(Continued on Page 16)

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BOOK REVIEWS

(Continued from Page 14)

appropriate remedy. It will assist in bringing back the often lost powers of resistance against colds and, what counts even more in an age of preventive medicine, it has proved its value as an excellent aid in the prevention of colds.

Primer of Allergy. A Guidebook for Those Who Must Find Their Way Through the Mazes of This Strange and Tantalizing State. By Warren T. Vaughan, M. S., M. D., Richmond, Virginia. Second Edition. Cloth. Pp. 176, with illustrations by John P. Tillery. St. Louis: The C. V. Mosby Company, 1943.

The volume is distinctly utilitarian since it was created to fulfill a need which the author had experienced, for a small A-B-C of the subject from which his patients may attain sufficient insight into their problem to be able to coöperate intelligently in the effort to bring them relief from their vexing symptoms. Since other physicians treating the same maladies have often mentioned the need for a book of this type, it has been so arranged that it may be similarly used by others.

The author expresses the hope that the book will enable patients who experience allergic symptoms, to gain a more rational insight, and to adjust themselves with greater success to those environmental factors which contribute to their discomfort.

The Principles and Practice of War Surgery. With Reference to the Biological Method of the Treatment of War Wounds and Fractures. By J. Trueta, M. D., Formerly Director of Surgery, General Hospital of Catalonia, University of Barcelona; Assistant Surgeon (E. M. S.) Wingfield-Morris Orthopaedic Hospital, Oxford; Acting Surgeon in Charge, Accident Service, Radcliffe Infirmary, Oxford.

(Continued on Page 17)

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BOOK REVIEWS

(Continued from Page 16)

With introduction by Owen H. Wangensteen, M.D., Minneapolis, Minn. Cloth. Pp. 439, with 144 text illustrations. St. Louis: The C. V. Mosby Company, 1943.

The author states in his preface that when the results obtained with the biological method of treatment of war wounds and fractures that forms the subject of this book were first reported in Great Britain, the immediate reaction was one of skepticism. This did not surprise him, for he had seen the same reaction among his fellow countrymen, the Catalan surgeons, in 1934, and among the surgeons of the Spanish Republican Army in 1938, and among French surgeons in 1939.

Much has happened since then, however, and the spread of the war has offered many occasions for putting the treatment, and the claims made for it, to the test.

The second fact which emerges from experience in Great Britain is that the quality of the results is to a large extent independent of the surgeon's skill. Success depends mainly on a clear understanding and careful practice of the principles on which the method is based.

One of the chief aims of the author in his present work is to supply all the details of technique that his earlier volume lacked.

The author tells his readers that they who have the patience to persevere to the end of the book will realize that there is little new in the technique described; on the contrary, most of its components have been used and described in the past. His main contribution has been to combine several established principles so that the benefits of each might be increased by their logical use in a single method of treatment.

The volume will stimulate thought on the subjects considered.

Eye Hazards in Industry. Extent, Cause, and Means of Prevention. By Louis Resnick. Published for the National Society for the Prevention of Blindness. Cloth. Price, $3.50. Pp. 321, illustrated. New York: Columbia University Press, 1941.

The National Society for the Prevention of Blindness has been concerned with the eye hazards of industrial occupations for more than a quarter of a century. This concern has been serious and active, not academic. As early as 1917 this organization published the first handbook dealing with these hazards.

Today the National Society for the Prevention of Blindness is more than ever concerned with the eye hazards of industrial occupations, because despite all the progress that has been made toward their control these hazards still constitute one of the principal causes—if not the one most serious cause—of blindness and defective vision.

Thousands of industrial concerns have no contact with any national or local safety organization. It is in these concerns particularly that workers are blinded, and others suffer partial but serious impairment of vision from causes which are wholly preventable.

Much attention is given in this volume to the monetary cost of industrial eye injuries and eye diseases, and the reason for this emphasis is explained.

Good sight is a prerequisite to skilled craftsmanship, whether it be in the shop, in the field, in the air, or on the high seas.

The Kenny Concept of Infantile Paralysis and Its Treatment. By John F. Pohl, M. D., Clinical Assistant Professor of Orthopedic Surgery, University of Minnesota; Attending Orthopedic Surgeon, Minneapolis General Hospital, in collaboration with Sister Elizabeth Kenny, Honorary Director of the Elizabeth Kenny Clinics of Australia; Honorary Director of the Elizabeth Kenny Institute, Minneapolis; Guest Instructor, University of Minnesota Medical School, with

(Continued on Page 20)

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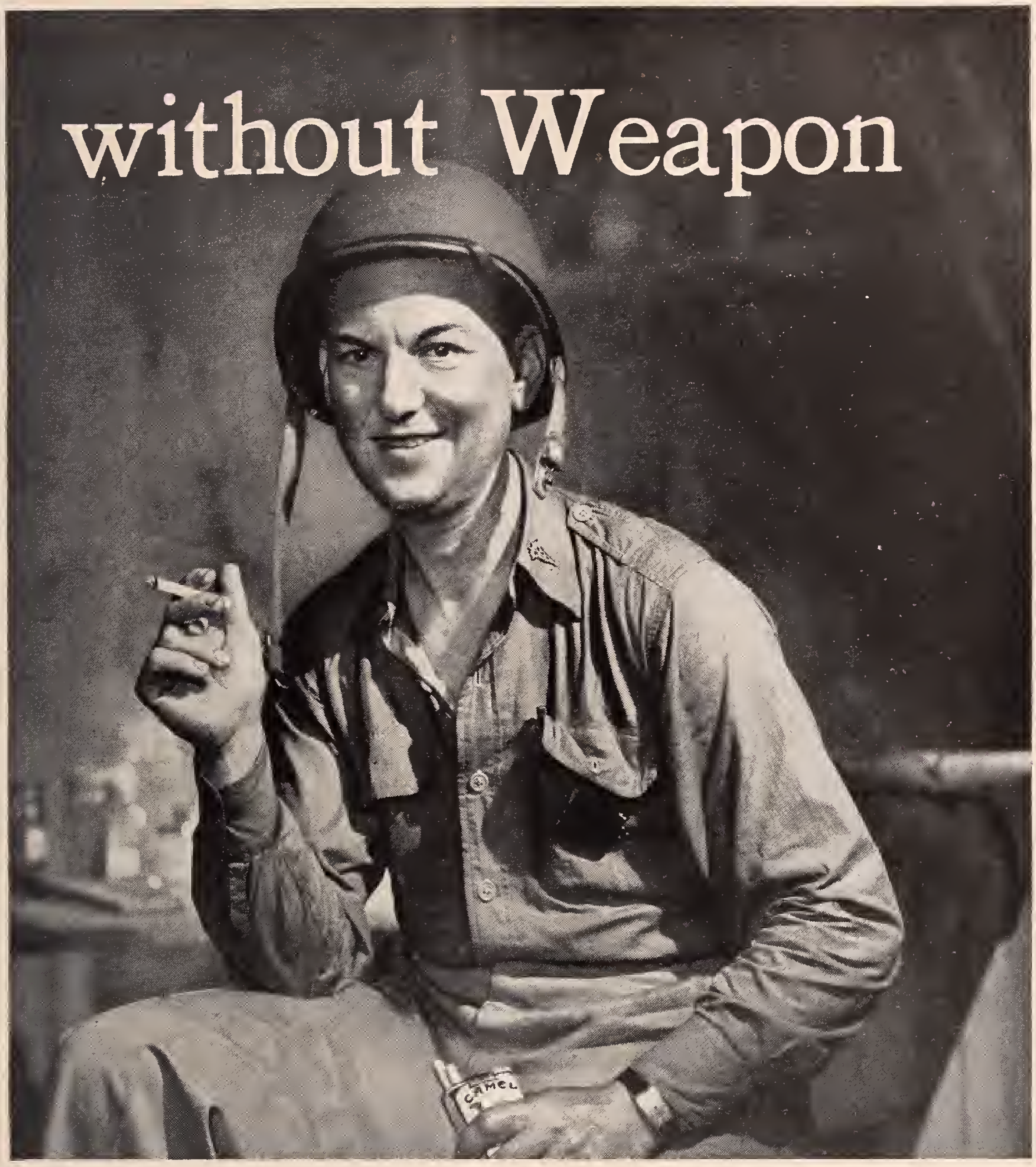

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New reprints available on cigarette research—Archives of Otolaryngology, February, 1943, pp. 169-173—March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

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BOOK REVIEWS

(Continued from Page 17)

a Foreword by Frank R. Ober, M. D., President, the American Orthopedic Association. Cloth. Price, $5. Pp. 368, with 114 explanatory photographs. St. Paul and Minneapolis: Bruce Publishing Company, 1943.

During the first three decades of her work in Australia and England, a great many listened to the story of Sister Elizabeth Kenny, and but few were convinced that her treatment was good. Never, before coming to the United States, was she able to work side by side with clinicians, scientists, research workers, preparing a complete and connected picture of her ideas and methods. The anatomists, physiologists, pathologists, as well as pediatricians, orthopedic surgeons, and men in physical medicine have studied her results and her methods.

The National Foundation for Infantile Paralysis has sponsored and directed a broad program of research in connection with Miss Kenny's work. Not only has it supported Sister Kenny and her staff at the University of Minnesota, but it has financed other investigative and instructional programs in many laboratories, medical schools, and hospitals throughout all of the United States.

This volume on Infantile Paralysis is an up-to-date discussion of the techniques now being advocated by Sister Elizabeth Kenny. The reader will find a well-conceived plan for the relief of pain and muscle spasm by the early and continued use of hot packs and a well-defined plan for reëducation of the neuromuscular system.

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(Continued on Page 22)

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*Hirsch, M. M., and Novak, M. V.: Evaluation of Germicides with Relation to Tissue Toxicity. Proc. Soc. Exper. Biol. and Med., June, 1942.

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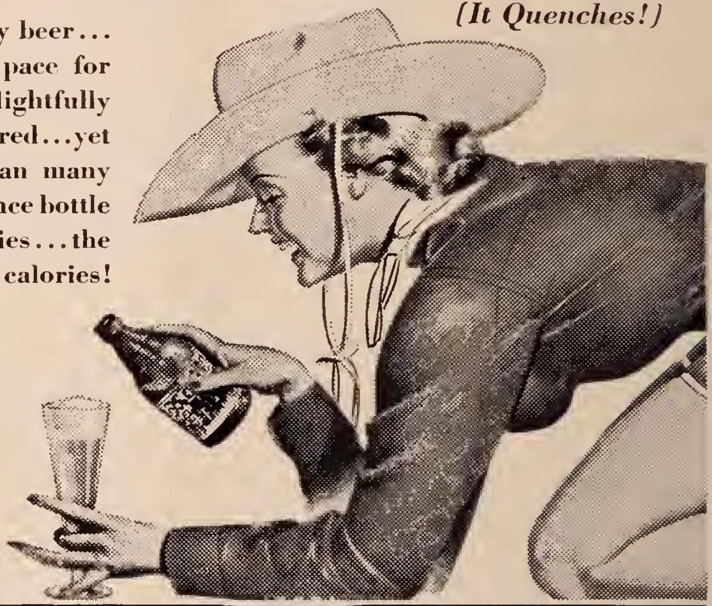

BOOK REVIEWS

(Continued from Page 20)

Synopsis of Diseases of the Skin. By Richard L. Sutton, M. D., Emeritus Professor of Dermatology, University of Kansas Medical School, and Richard L. Sutton, Jr., M. D., Assistant Professor of Dermatology, University of Kansas Medical School. Cloth. Pp. 481, with 413 illustrations. St. Louis: The C. V. Mosby Company, 1942.

This book is intended to present in compact form a general view of diseases of the skin. Simplicity, practicality, and condensation were the aims, dwelling longest on the elementary and the commonplace, least on the exceptional, and emphatically on the utilitarian. Illustrations were carefully planned, adhering to a ratio of almost a picture a page. More than 750 volume and page citations of pertinent literature are incorporated in the text, so that greater detail and original contributions may readily be studied according to desire or assignment.

Flying Men and Medicine. The Effects of Flying Upon the Human Body. By E. Osmun Barr, M. D., with an introduction by James H. Defandorf, Colonel, United States Chemical Warfare Service, and a Foreword by Bernard L. Jarman, M. D., Lieutenant Colonel, Medical Corps, U. S. R. Cloth. Price, $2.50. Pp. 270, illustrated with drawings and diagrams. New York and London: Funk and Wagnalls Company, 1943.

This book has been written especially for the prospective flier. Its aim is to present, in nontechnical language, those medical aspects of aviation which determine whether the individual is suited, physically and mentally, to undertake the exacting training which the profession of flying requires, how he can prepare himself for examination, and how to maintain his efficiency after he has qualified as an aviator.

The volume should meet the long-needed demand for enlightenment on this subject in a style which is intelligible to the layman. The influence of flying on the functioning of important systems and organs of the body is discussed, disqualifying physical and mental defects are described and wherever possible remedial measures are recommended.

The volume is one of the first of its kind to present this important phase of medicine to the air-minded layman. It is a fairly comprehensive discourse on air medicine that is both explanatory and informative, written in nontechnical terms.

Convulsive Seizures: How to Deal with Them. A Manual for Patients, Their Families and Friends. By Tracy J. Putnam, M. D., Professor of Neurology and Neurosurgery, College of Physicians and Surgeons, Columbia University; Director of Services of Neurology and Neurosurgery, Neurological Institute of New York. Cloth. Price, $2. Pp. 158, with 12 illustrations. Philadelphia: J. B. Lippincott Company, 1943.

Patients and their relatives, on first coming to grips with the fact of recurrent attacks of seizures, are beset with a bewildering and terrifying host of problems. Such questions as, "What are the chances for recovery?", "What is 'epilepsy'?", "What occupation should the patient seek?", "What limitations upon his activity are imposed by law?", appear with unvarying constancy.

It is a large part of the doctor's duty to answer them to the best of his knowledge, and to encourage the asking of more. But it usually happens that many questions remain unasked, unanswered, or misunderstood, in a situation in which comprehension is vital to the patient. This manual might be considered primarily as an extended consultation, reduced to print for reference. The manual is intended to meet the needs of patients. The royalties from the sale of the present edition of this book will be turned over to a fund for the study of the diseases of the nervous system.

(Continued in Back Advertising Section, Page 30)

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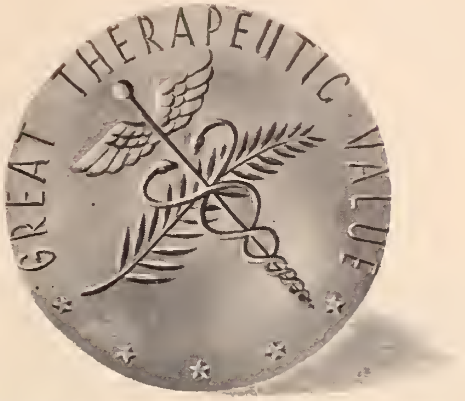

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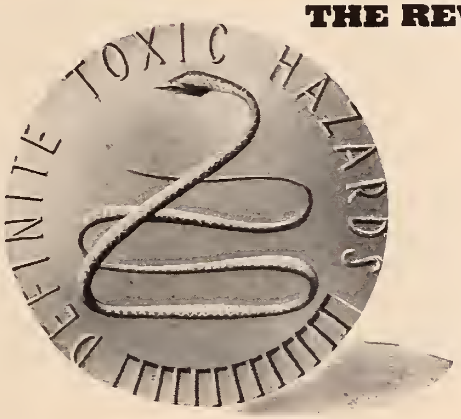

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CALIFORNIA AND WESTERN MEDICINE

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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

CALIFORNIA MEDICAL ASSOCIATION WILL HOLD AN ANNUAL SESSION IN 1944

Meeting Will Be Held in San Francisco.—At its 312th meeting, the Council of the California Medical Association voted to hold the seventy-third annual session in San Francisco, war conditions permitting. The first week or so in May will probably be the time for the two-day, Sunday and Monday, session.

The program arrangement of this year's session at Los Angeles will be followed: general organization meeting, on Sunday morning; general meeting, with surgical topics stressed, on Sunday afternoon; dinner to President Karl L. Schaupp, on Sunday evening; general meeting, with subjects on internal medicine emphasized, on Monday morning; meetings of the twelve scientific sections, on Monday afternoon. In addition, the Council has authorized a provisional new section meeting—on public health. Under existing war conditions, topics related to military medicine and to war industrial and civilian areas will continue to receive special consideration.

* * *

Prospective Essayists to Take Notice.—The attention of component county societies and members is called to the above at the present time, in the hope that members who are in position to submit papers will communicate with the respective section officers whose names appear in each issue of CALIFORNIA AND WESTERN MEDICINE, always in the front advertising section, on page 6.

In due course, other information will appear in the CALIFORNIA AND WESTERN MEDICINE department of the Committee on Scientific Work.

UNITED STATES NURSE CADET CORPS

Doctor and Nurse Shortage.—Much has been written concerning the shortage of doctors in civilian areas. Also, the medical corps of the Army and Navy have been urging the enlistment of all available physicians under the age of forty-five, to permit the military needs for medical officers to come up to personnel standards.

During the time the discussion regarding the requirements concerning physicians has been going on, the shortage of nurses in both the military nurse corps and in civilian hospitals and private practice has become more and more apparent.

Congresswoman Bolton's Act Creates the United States Cadet Nurse Corps.—The Bolton Act, enacted by Congress on July 16, 1943, establishes what is known as the United States Cadet Nurse Corps, through which it is hoped, within the coming months, to bring about the recruitment of some 65,000 cadet nurses, who will receive training in accredited schools in which an accelerated training program of some thirty months is offered.

Already enlisted for service in the armed forces are some 36,000 nurses; and it is hoped to bring about the recruitment of an additional 36,000 graduate nurses during the first six months of 1944, the American Red Cross having agreed to take an active part in this effort.

The new United States Cadet Nurse Corps, through the Bolton Act, will aim to recruit some 65,000 new student nurses during the coming year. These student cadet nurses will receive maintenance, uniforms, and nominal stipends from the Government during the training period, an innovation in nurse training that may be construed as an indication of the gravity of the nurse shortage problem.

* * *

Woman's Auxiliary to the California Medical Association Will Give Active Support.—At the meeting of the officers of the Woman's Auxiliary to the California Medical Association held in Berkeley on Wednesday, September 8, Mrs. Eben Carey, president of the national auxiliary, stated that the Woman's Auxiliary to the American Medical Association, through the members of its constituent state auxiliaries and their component county units, had accepted the responsibility of securing many of the needed recruits for the United States Cadet Nurse Corps. Full information will be transmitted at an early date to the members of the Woman's Auxiliary to the California Medical Association. (See also on pages 188-189.)

CALIFORNIA MEDICAL ASSOCIATION COUNCIL MINUTES OF AUGUST 22, 1943 MEETING

Importance of Official Transactions.—The business proceedings of a state medical society are found in the minutes of meetings of its House of Delegates, Council, and other constituted authorities. The records so presented indicate policies adopted on behalf of Organized and Scientific Medicine. Acknowledging the importance of official proceedings, it is probably true that minutes, as printed in official journals of constituted state medical organizations, are read by only a small number of members. This is to be regretted, since with no contrary expression of opinion on issues concerning which there may be a basis for considerable difference of opinion, the officers who are responsible for the formulation of policies and actions are not informed whether their own views have been favorably or unfavorably accepted by members at large.

In the current issue appear the minutes of the 312th meeting of the California Medical Association Council. The summary presented, outlines briefly the important decisions reached in an entire day of earnest exchange of opinion between councilors and invited guests.

* * *

Next Council Meeting on October 10: Suggestions Invited.—Mention is made of this in the hope that members of the Association who maintain interest in present trends of medical practice will take the time to read the recorded proceedings and feel free to express their opinions thereon to their district councilors. The next meeting of the Council will be held in Los Angeles on October 10. Decision on some of the tentative plans proposed at the August 22 meeting may then be taken. The California Medical Association councilors will be able to proceed with more assurance if, in the meantime, members of the Association will communicate to officers their views on some of the plans that will come up for further consideration.

MATERNITY AND PEDIATRIC PLAN OF FEDERAL CHILDREN'S BUREAU

Recent Comments in "The Journal of the American Medical Association."—Concerning the very important subject of maternity and pediatric care to wives and children of enlisted men as put forth in a plan promulgated by the Federal Children's Bureau, Editor Morris Fishbein, in *The Journal of the American Medical Association* for August 28, has seen fit to touch upon some of the grave implications involved.

Comment which has appeared in CALIFORNIA AND WESTERN MEDICINE in its last three numbers, and particularly the editorial statements in the August issue, seem to have ruffled somewhat the mental equilibrium for which Editor Fishbein is supposed to be noted.

* * *

California Medical Association Fully Agrees That Adequate Maternity-Pediatric Care Must Be Given.—When Doctor Fishbein begins his editorial with the statement, "CALIFORNIA AND WESTERN MEDICINE for August, 1943, takes to task the action of the Federal Children's Bureau in providing payment for the obstetric care of the wives of enlisted men and for the care of their children," he does not give evidence of the clarity in thinking that has so often delighted his readers and listeners. True, he added the modifying clause in a sort of reverse English, "objection is not made to the payment or to the care, but to the technique and rate of payment." However, the placement of the supplementary phrase appeared after the first impression—an erroneous one—might have been drawn.

Let it again be emphasized that at no time have the constituted authorities of the California Medical Association or its OFFICIAL JOURNAL stated aught to indicate opposition to a program designed to give adequate medical service to the wives and infants of enlisted men. That is not the question at issue.

Objection Is to the Procedure Regarding Payment for Services Rendered.—Perusal of the statements and resolutions of the constituted authorities of the California, Michigan, and Ohio State Medical Associations, the Pacific States Medical Executives' Conference, and other organizations, will show that they did not criticize the "Federal Children's Bureau in providing payment for the obstetric care of the wives of enlisted men and for the care of their children." Their objections were raised against the *method* of payment promulgated by the Federal Children's Bureau, since the payments to physicians instead of to the wives of enlisted men is a menace to medical practice as it exists today and should be carried on in the future.

The Journal of the American Medical Association prints, with minor deletions, the forthright statements of the Council of the Michigan State Medical Society in which the principles involved are clearly put—as given in California and Western Medicine for August, on pages 105-106.

* * *

A Correction in Statement.—Editor Fishbein, in editorial comments, states that California and Western Medicine "calls attention to what are said to be the *only* two items on the subject which appeared in *The Journal*."

The word *only* has been emphasized above because it was not used by California and Western Medicine, the actual words being, "The following items have been noted in *recent* issues of *The Journal of the American Medical Association*." As elsewhere stated, the long list of incidental and other non-editorial references to the Federal Children's Bureau plan was received after the August issue of California and Western Medicine was in press—too late to be given printing in the same number. In this issue, the list referred to appears on page 178, under Item XX.

Criticism was made by California and Western Medicine because *The Journal of the American Medical Association* has not given editorial emphasis to the important subject. The silence was the more difficult to understand, since Editor Fishbein has acquired a considerable reputation for pungency in use of both the written and spoken word.

* * *

May 30 Resolutions of Pacific States Medical Executives' Conference.—The resolution presented by Dr. John H. Fitzgibbon of Portland at the American Medical Association House of Delegates in June was written for the Pacific States Medical Executives' Conference at its Portland meeting on May 30 by the editor of California and Western Medicine, who was a member of the Reference Committee of that conference. That resolution emphasized the principle of "leaving the actual arrangements, with respect to fees, to be fixed by mutual agreement with the wife and the physician of her choice." (*Journal of the American Medical Association,* June 26, page 621.)

That obstetric service to wives of enlisted men would be rendered by physicians anywhere and at all times to women in need of such care has never come into question. To give obstetric service the medical profession has always committed its members, and that with or without pay, and whether the patients were or were not the wives of enlisted men.

However, the plan for paying as outlined by the Federal Children's Bureau, whereby the payment must be made by a constituted state authority to physicians instead of to the patients, involves a principle in which the medical profession is much interested.

As stated in *The Journal of the American Medical Association,* in reference to the action of the American Medical Association House of Delegates in June, 1943, in considering the resolution submitted by Doctor Fitzgibbon, "It was the belief of the House of Delegates that the funds available should be paid to the patient and that the matter of payment to be rendered was a matter for determination between the patient and the physician." Nevertheless, the Federal Children's Bureau stands on its rights not to make such a ruling or regulation, thus inflicting an almost arbitrary fee schedule on physicians, for not one state, but for all states of the Union.

Had proper action been taken in ample time, it might have been possible to have developed a solution different from that which is now offered by the Federal Children's Bureau, which in essence and roughly put to physicians could be stated somewhat as follows:

"Take our grant-in-aid the way we offer it through your state board of health—that is, as physicians, accept these patients according to the procedure laid down in Washington, or lay yourselves open to criticism in the public press and elsewhere as being unwilling to do your part in the war effort."

Reference to Ohio and Oregon press articles which appear in this issue reflect light on the above. (See pages 181-182.)

* * *

In Conclusion.—It is our regret in California that the importance of the issues at stake seemingly were not grasped and portrayed by those of our national authorities who were in position to contact and give the necessary information concerning obstetric fee schedules to the representatives of the Federal Children's Bureau. Had such a course been followed, fee schedules of some years ago, secured from the United States Public Health Service, would not have been used by the Federal Children's Bureau, to be presented subsequently to the committees of constituent state medical associations as the authoritative background for a mandatory fee schedule that in many commonwealths is below the actual cost of the services rendered. (Services demanded by the Federal Children's Bureau include prenatal care from the day the physician accepts the patient, with urinalysis, Wassermann, and hemoglobin examinations; confinement care; and postpartum care, with last visit at least six weeks after the confinement. Payment for all the above services to be $35 to $50.)

It is agreed that the entire experience has been unpleasant. Nevertheless, on important matters it is sometimes better to be frank than silent in portrayal of a point of view. It is hoped that what has appeared in CALIFORNIA AND WESTERN MEDICINE may bring about a better understanding of the basic issues involved, at least for members of the California Medical Association, and to action that may lead to correction of deficiencies.

EDITORIAL COMMENT†

INDIVIDUAL-SPECIFIC HUMAN PROTEINS

In studies of gene-determined plasma proteins in hybrid pigeons and doves, Irwin[1] and his coworkers of the Department of Genetics, University of Wisconsin, found several minor serum proteins by means of which individual pigeons can be differentiated from one another in spite of their apparent erythrocytic identity. To test for the existence of similar individual plasma specificities in man,[2] rabbits were repeatedly injected with the same individual human serums. Antiserums thus prepared gave positive precipitin reactions with all human serums. When all of the common human precipitins were absorbed with the serum proteins of a second individual, there were often nonabsorbed precipitins, reacting only with the serum of certain individuals. Data from such absorption tests suggest that, in addition to the major serum proteins common to all humans, there are at least four minor proteins which may be present or absent in certain individuals and whose presence or absence is independent of routine blood grouping. The reported titers suggest that these minor individual-specific proteins may constitute as much as one per cent of the total serum. Proof that similar individual proteins are gene-determined in hybrid pigeons suggests that they are presumably also hereditary characters in man. This is in line with the alleged racial differences in human serums previously reported by Smith.[3] It should be emphasized, however, that proof of the antigenicity of these minor serum factors for rabbits is not proof of their antigenicity for man. Irwin's data are of current clinical interest in their bearing on the controversial problem of human plasma toxicity.

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W. H. MANWARING,
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TUBERCULOSIS HYPERPOLYSACCHARIDEMIA

The possibility of developing a reliable prognostic test in tuberculosis is suggested by quantitative studies of the polysaccharide content of tuberculosis serums recently reported by Seibert[1] and associates of the Henry Phipps Institute, Philadelphia.

It was previously shown by the same serologists[2] that there is a consistent increase in the amount of gamma globulin in human serum during the course of tuberculosis. Since there is not a sufficient increase in specific antibodies to account for this increase, attention was turned to a study of the tuberculosis polysaccharides known to be present in tuberculosis serums and which migrate in electrophoresis with approximately the same mobility as gamma globulin.[3] Polysaccharide was determined directly in such serums or serum fractions, without preliminary hydrolysis, by means of the carbazole color reaction.[4]

The results of these tests showed 2.4 per cent polysaccharide bound to the gamma globulin of tuberculosis serum and 3.3 per cent polysaccharide bound to the albumin fraction. This is approximately twice the amount demonstrable in nontuberculous controls, confirming data reported by previous investigators.[5] Since this polysaccharide attaches itself to the largest extent to serum albumin, Seibert is of the opinion that it does not represent polysaccharide formed by the tubercle bacillus. It is presumably either an increased amount of a normal tissue polysaccharide or some secondary pathological product associated with the tuberculous process.

The Phipps Institute serologists tested the possible correlation between polysaccharide titer and the clinical severity of tuberculosis. In thirteen nontuberculous control patients the serum polysaccharide (*i. e.*, total polysaccharide minus glycogen) varied from 88 to 133 mg. per 100 c.c., averaging 114 mg. per cent. In ten cases of minimal tuberculosis the titers varied from 129 to 184 mg. per 100 c.c. In certain advanced cases the titers were as high as 194 to 211 mg. per cent. In this latter series relatively low titers were noted in certain patients who showed marked improvement following x-ray therapy.

While the attempted correlation between polysaccharide titer and clinical severity has given encouraging results, the suggestive prognostic values of this polysaccharide assay cannot be established until larger numbers of cases have been followed over longer periods of time. The immunochemical specificity and antigenicity of the Seibert polysaccharides have not yet been determined.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

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BIOTIN IMMUNITY IN PROTOZOAN INFECTIONS

It has long been known that famine is frequently accompanied by severe epidemics of malaria, from which it has been deduced[1] that malnutrition lowers normal resistance to pathogenic protozoa. Experimental evidence, however, has contradicted this deduction. Passmore and Sommerville,[2] for example, found that monkeys maintained on a famine diet did not develop severer infections with *Plasmodium cynomolgi* than did adequately fed controls. That there is an element of truth in the prevalent belief, however, is currently reported by Trager[3] of the Rockefeller Institute, and by Caldwell and György[4] of Western Reserve University, who have studied the effects of biotin deficiency and biotin therapy on malaria and trypanosome infections in laboratory animals.

Du Vigneaud[5] of Cornell University had previously alleged a correlation between the biotin titer of the blood of fowls and the severity of avian malaria infection. Applying this finding, Trager produced biotin deficiency in chickens and ducks by feeding them adequate diets plus a large amount of dried egg white. (The avidin of the egg white functions as an antibiotin.) Control animals were fed the same diet plus an equivalent amount of casein. Ducks on the egg-white diet began to show signs of biotin deficiency in two to four months. At or before this time the animals, together with an equal number of casein-fed controls, were inoculated intravenously with the same dose per unit of body weight of the blood of a malaria-infected donor.

As a typical experiment, five ducks that had been fed for fourteen days on the egg-white diet together with five casein-fed controls were each inoculated intravenously with the blood of the same malarial donor. After a lag phase of about forty-eight hours, the plasmodium count increased logarithmically in the blood of each animal. In the control ducks the average count reached 40 plasmodia per 100 r. b. c. by the fifth day. In the biotin-deficient ducks the count was 90 plasmodia per 100 r. b. c. on the same day. This is a 100 per cent increase in the severity of the infection in the malnutrition group. There was even a greater difference in the relative mortality of the two groups; only one of the casein-fed controls died on the sixth day, while there were four deaths in the biotin-deficient group. Similar differences were noted in chickens.

In both chickens and ducks the increased severity in the malnutrition group was proportional to the degree of biotin deficiency. This finding was confirmed by therapeutic tests, intraperitoneal injections of biotin concentrate into the deficiency animals, restoring their normal antimalaria resistance. Similar injections in animals fed adequate diets, however, had no demonstrable antimalarial effect, presumably due to rapid destruction in elimination of excess biotin.

Almost identical results are reported by the Western Reserve pediatricians, who studied the effects of a biotin deficiency in trypanosome infections. Several groups of rats were maintained on a modified egg-white diet, with controls reared on their routine stock diet. In a typical experiment, ten rats showing a fairly advanced stage of biotin deficiency together with thirteen adequately fed controls were each inoculated intraperitoneally with the same number of *Trypanosoma lewisi*. The resultant infections lasted from 7 to 28 days in the control group, an average of 16.9 days. In the biotin deficiency group the infection lasted from 14 to 49 days, an average of 34.9 days. Similar, though less pronounced, prolongations of the infection were noted in rats showing moderate or slight degree of biotin deficiency and even in those with a latent deficiency. Prolongation of the trypanosome infection could also be prevented in rats by daily subcutaneous injections of biotin concentrate during the course of the experimental infection.

Among the significant phenomena reported by Trager is his finding that the biotin level of the circulating blood of normally fed fowls increases rapidly during the early stages of experimental malarial infections, a phenomenon originally reported by certain Asiatic clinicians.[2] As soon as the biotin blood titer had reached its maximum, the plasmodia cease to multiply. Trager believes the increase in humoral biotin titer is due to a biotin release from the liver or from other storage tissues. Synthesis of biotin by the invading protozoan parasites, however, has not yet been ruled out.[4] Hyperbiotinemia is pictured by both investigators as an immunity mechanism. The excess biotin presumably inhibits protozoan infections either by its direct toxic action on the parasites,[3] or by activating antibodies or defensive enzymes.[4]

While the suggested theory of biotin immunity is controversial, it does furnish an ephemeral working hypothesis of major theoretical and clinical interest.

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Minorities are rich assets of democracy, assets which no totalitarian government can afford. For the majority itself is stimulated by the existence of minority groups. The human mind requires contrary expressions against which to test itself.—Wendell L. Willkie.

ORIGINAL ARTICLES

Scientific and General

VIRUS PNEUMONIA: ETIOLOGICAL STUDIES*

MONROE D. EATON, M. D.
Berkeley

THE term "atypical pneumonia" is generally used to denote a primary pneumonitis or bronchopneumonia without known bacterial etiology. In this group of diseases a causative virus is demonstrable in not more than 10 per cent of cases. The cause of most forms of bronchopneumonia or pneumonitis is unknown, but it has been assumed that a virus, or possibly several different viruses, may be the causative agents. This discussion must necessarily be limited to those forms of pneumonia from which viruses have been isolated. In the group of known etiology there are four varieties, each caused by a different virus.

TYPES

Influenza.—Pneumonia may be produced by the virus of influenza. In fatal cases of influenzal pneumonia the virus has been isolated from the lung tissue obtained at autopsy. Although various species of bacteria are generally found to be associated with the virus in such cases, it is quite possible that influenza virus by itself may cause fatal pneumonia in man because this virus is capable of producing a pure virus pneumonia without secondary bacterial infection in experimental animals.

Isolation of influenza virus is accomplished by intranasal inoculation of ferrets with sputum or garglings from the nasopharynx of patients in the acute stage of illness. There are two antigenically distinct influenza viruses which are designated types A and B. Serological tests for influenza are done by measuring the ability of the patient's serum to neutralize or inactivate virus, the ability of the serum to fix complement in the presence of a specific virus antigen, or the inhibition by serum of the agglutination of chicken cells by influenza virus. The serum of most normal individuals contains antibodies to influenza virus so that the demonstration of these antibodies by itself has no diagnostic significance. In order to make a specific diagnosis by serological test, it is necessary to compare the titer of antibodies in a serum specimen taken soon after the onset of illness with the titer of a specimen taken ten days or more after the first specimen. An increase in antibodies to either type A or type B influenza virus associated with illness establishes the type of influenza. Influenzal pneumonia caused by the type A virus is, according to present knowledge, only associated with epidemics in which there are large numbers of cases of uncomplicated influenza caused by the same virus.

Rickettsiae.—A second kind of pneumonitis may be caused by certain rickettsiae. When Q fever, which is a rickettsial disease, was first described in Australia, no lung involvement was recognized. However, Dyer, Topping, and Bengston[1] isolated the rickettsia of American Q fever from cases of pneumonitis which were apparently the result of infection in the laboratory. The virus of Q fever and many other species of rickettsiae may be isolated by intraperitoneal inoculation of guinea pigs with blood taken during the acute febrile stage of the illness. Serological tests are performed by agglutination or complement fixation, with suspensions of rickettsiae and serum taken ten days or more after the onset of illness. The Weil-Felix reaction is negative in Q fever and has, therefore, no diagnostic significance in this disease. Recently serum specimens from cases in at least three separate outbreaks of pneumonitis have been tested with Q fever virus with negative results. Up to the present, Q fever pneumonitis has not been found except as a laboratory infection in the United States.

Psittacosis.— Psittacosis virus produces a disease characterized by a typhoid syndrome with wandering pneumonia. This disease results from contact with infected birds of the parrot or finch families, certain sea birds, and possibly pigeons. Psittacosis is not frequently transmitted from one human being to another. The virus is isolated by inoculating mice intraperitoneally with sputum or blood. The most commonly used serological test is the complement fixation method. However, recent investigations have shown that this test gives a group specific reaction which is not necessarily diagnostic of psittacosis.

Other Strains.—In 1940 we reported the isolation of a new virus from cases of severe atypical pneumonia by intranasal inoculation of mice.[2] This year another strain of this same virus has been isolated. It is of some interest that three of the five patients from which this virus was isolated were nurses who apparently contracted their illness by taking care of patients with a similar form of pneumonia. This finding suggests that the virus is quite readily transmitted from one human being to another, but so far only small outbreaks have been observed. The case fatality of this disease is high, probably being 50 to 80 per cent.

The agent which caused these pneumonias was at first thought to be a variant of psittacosis virus, but subsequent investigations have shown that it is a member of a group of viruses which includes not only psittacosis, but also the virus of lymphogranuloma venereum, the virus of meningopneumonitis[3] and the virus of mouse pneumonitis recently isolated by Nigg.[4] The members of this group of agents are characterized by the formation of minute coccoid elementary bodies, by the possession of common antigenic components, and by similarities in pathogenicity for experimental animals. Relationships and differences between these viruses are shown in the first table.

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* From the International Health Division of The Rockefeller Foundation and Director of the Research Laboratory, California State Department of Public Health.

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TABLE 1.—*Relationships and Differential Properties of Psittacosis-like Viruses*

Reference Number	Name	Source	Differential Pathogenicity in Mice Meningitis	Peritonitis	Pneumonia	Carrier State	Cross Immunity Against
1	Lymphogranuloma venereum	Man	+	0	+	+	3, 2?, 5?
2	Psittacosis	Birds	+	+	+	+	3, 4
3	Meningo-pneumonitis	Ferrets	+	±	+	±	1, 2, 4
4	Human pneumonitis	Man	+	0	+	0	1, 2, 3
5	Mouse pneumonitis	Mice	0	0	+	+	1?, 3?

Viruses of this group have been isolated not only from man and birds, but also from ferrets and mice by intranasal passage of lung material. Four of them produce fatal meningitis after intracerebral inoculation into mice, the exception being the mouse pneumonitis virus. Only one, psittacosis, is highly virulent for mice by the intraperitoneal route. All five agents produce pneumonia of a similar type in mice after intranasal inoculation. When mice are immunized against one virus in the group, they also possess a partial immunity to other members of the group. These results are summarized in the last column by reference numbers. Mice immunized with the virus of lymphogranuloma venereum have some immunity to intracerebral inoculation with the virus of meningopneumonitis, but cross-immunity to psittacosis and the mouse pneumonitis virus is irregular. Mice immunized with human pneumonitis virus were partially immune to intracerebral inoculation with the virus of lymphogranuloma venereum, psittacosis, or meningopneumonitis. Similar relationships of the meningopneumonitis virus were demonstrated.

TABLE 2.—*Cross-reactions by Complement Fixation with Human Sera*

Human Serum	Immune to	Complement Fixation Titers With Lymphogranuloma Venereum	Meningopneumonitis	Mouse pneumonitis
H 1	Pneumonitis*	16	16	32
H 2	Pneumonitis*	64	32	N. T.
H 3	Pneumonitis	16	8	16
H 9	Lymphogranuloma venereum*	64	16	16
H 10	Lymphogranuloma venereum	32	16	16
H 12	Psittacosis*	32	16	N. T.
H 16	Psittacosis*	64	64	N. T.

* Strong reaction with psittacosis antigen.
N. T.—Not tested.

Table 2 shows the complement-fixation reactions of human sera with antigens prepared from the viruses of lymphogranuloma venereum, meningopneumonitis, and mouse pneumonitis. Sera from cases of pneumonitis proved by isolation of virus, and also sera from cases of lymphogranuloma venereum and psittacosis, gave group specific reactions with the viruses of lymphogranuloma venereum, meningopneumonitis, and mouse pneumonitis. The titer of normal human serums with these antigens is four or less. Some of the sera were tested with psittacosis antigen in Dr. K. F. Meyer's laboratory and were found to give strong fixation of complement. The results in this table illustrate the group specific character of the reaction and this has been observed with many other samples of human serum not only from pneumonitis cases, but also from cases of lymphogranuloma venereum.

Despite the fact that the complement-fixation test with this group of viruses was not specific for any one member of the group when applied to human serum, it was considered of some interest to determine what proportion of cases of atypical pneumonia and of uncomplicated upper respiratory disease gave the reaction. For this purpose, antigens from the viruses of lymphogranuloma venereum and meningopneumonitis were used. The results are shown in Table 3. In five of seventeen cases of pneumonitis tested with the virus of meningopneumonitis the convalescent serum showed a definite increase in titer of 8-fold or greater over the serum taken during the acute phase of illness. Similar definite increases were observed in six out of sixty-one cases tested with the virus of lymphogranuloma venereum. In other cases increases in titer of lesser degree were observed. One case of upper respiratory disease having the symptoms of influenza showed a definite increase in titer with both antigens. This case gave negative serological tests for influenza types A and B. In a few other cases of upper respiratory disease, slight increases were observed.

TABLE 3.—*Complement Fixation Tests With Acute and Convalescent Serums*

Disease	Antigen	Number Tested	Change in Titer Associated With Illness No Increase Number	Slight Increase Number	Definite Increase Number
Pneumonitis	Meningopneumonitis	17	9	3	5
Upper respiratory	Meningopneumonitis	80	76	3	1
Pneumonitis	Lymphogranuloma venereum	61*	43	12	6
Upper respiratory	Lymphogranuloma venereum	40	37	2	1

* Four cases showing increase in complement fixation titer with normal yolk sac not included.

In Table 4 are presented the results of tests on cases of pneumonia from which only convalescent sera were available. The results with convalescent sera from cases of upper respiratory disease are included for comparison. It will be seen that the proportion of persons having titers of eight or above with two antigens was relatively higher in the cases of pneumonitis than in cases of upper respiratory disease.

In about 15 per cent of the cases of pneumonitis the titers were over sixteen or well above normal limits. In many cases the results represent duplicate tests on the same serums with the two antigens. Usually the titers with lymphogranuloma and meningopneumonitis antigens correspond fairly closely. In only one case of upper respiratory disease was a high titer observed with the two antigens.

Table 4.—*Complement Fixation Tests With Convalescent Serum Only*

Disease	Antigen	Number Tested	Number With Titer of 0	4	8	16 or Over
Pneumonitis	Meningopneumonitis	64	30	14	10	10
Upper respiratory	Meningopneumonitis	76	60	14	1	1
Pneumonitis	Lymphogranuloma venereum	69	30	13	9	17
Upper respiratory	Lymphogranuloma venereum	40	29	5	5	1

DISCUSSION

These serological results indicate that some cases of atypical pneumonia may be caused by a virus antigenically related to those used as antigen in the complement-fixation tests. However, severe pneumonia caused by an agent directly transmissible to mice by intranasal inoculation appears to be a rare disease. Isolation of this virus was accomplished in only 2 out of 106 sputum specimens, and 3 out of 14 specimens of lung tissue inoculated into mice intranasally. No transmissible agent could be found in sputums of a number of patients whose serum gave positive or suggestive complement-fixation reactions with meningopneumonitis antigen.

At least 90 per cent of all cases of atypical pneumonia are not caused by any of the viruses just described. Possible etiological agents of these diseases have been isolated. Stokes, Kenney, and Shaw[5] found a virus that produced pneumonia and encephalitis in guinea pigs and mice, but this agent was subsequently lost. Weir and Horsfall[6] described a virus which they claimed was isolated from mild cases of atypical pneumonia, and which was infectious for the mongoose, but not any other species of animal tested. Because of the lack of readily available experimental animals, this mongoose virus cannot be studied very thoroughly in its relation to atypical pneumonia and no satisfactory serological test has been developed. At present the main problems in isolating new etiological agents from cases of atypical pneumonia seem to be the finding of a readily available susceptible animal, and the development of specific serological methods. In view of the recent introduction of new species of experimental animals, and the development of techniques of using chick embryos as culture mediums for viruses, it seems possible that isolation of new types of virus from cases of pneumonitis may be successful in the near future.[7]

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PRE-EMPLOYMENT EXAMINATIONS—UNUSUAL FINDINGS AT DOUGLAS AIRCRAFT CORPORATION*

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PHYSICAL examinations of individuals applying for employment in industry are objective rather than subjective. When pathology is found, it is usually more of a surprise to the applicant than to the examiner. Formerly applicants for work in the aircraft industry were usually young males. In the past year the picture has reversed itself, and to this there has been added an increasingly greater number of older men and women. Still more recently, and in the past few months, younger individuals of high school age are being employed. Thus, in the course of one year, many thousands of individuals of both sexes, ranging from 16 to 76 years, have been examined. (Due to military reasons exact figures must be deleted.)

SCOPE OF EXAMINATIONS

The examination of each applicant embraces a "strip" physical, including a pelvic examination for all but unmarried females. Smears are taken where indicated. Special eye examinations for visual acuity, Keystone testing, and color testing, using standard methods and charts, are performed. A routine flat plate x-ray of the chest is made for each individual and, when indicated, x-rays of other areas where pathology is suspected. A routine Kahn blood test, hemoglobin and blood cell count, is made for all applicants. A urinalysis is completed for all males. Females do not have a routine urinalysis made unless the examiner orders that specifically.

QUALIFIED EMPLOYMENT AND REJECTIONS

Rejections for employment have decreased from several per cent a year ago to less than .5 per cent now. Qualified and limited employment has been substituted in place of rejection. With this procedure, the acceptance of a potential hazard in physical disability as well as inability is inevitable. Conditions now prevailing indicate an acceleration in the employment of individuals with substandard physical findings.

In accepting an individual for qualified employment, due consideration is given to the hazard he or she creates by reason of the disability as well as the personal hazard the occupation offers. Regardless of the care used in placing the new employee, and especially the one with a physical disability, we are experiencing a great deal of difficulty by reason of the numerous requests for transfer from one job to another.

CLINICAL OBSERVATIONS

There are a few general observations which are apparent to every industrial examiner, but these are not always of the usual variety.

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* Read before the Section on Industrial Medicine and Surgery at the seventy-second annual session of the California Medical Association, Los Angeles, May 2-3, 1943.

Obesity.—When obesity is not complicated by cardiovascular disease, it has proved to be acceptable in younger individuals. It is a distinct hazard on the production line. Slow, awkward movements are dangerous. In older individuals in general, moderate to severe obesity has proved to be a personal hazard.

Hypertension.—Applicants have been accepted with systolic pressures as high as 170, and diastolic pressures of 110, where no demonstrable myocardial or renal insufficiency was associated. There have been two instances of cerebral hemorrhage in this group. There are several hundred employees with elevations of blood pressure as high as these figures. Of the two cases mentioned, one was a 72-year-old female, who sustained a right partial hemiparesis during her first four hours of work. The other was a male, age 46 years, who developed a partial aphasia without motor impairment.

Valvular Heart Disease.—In younger individuals, where there is no myocardial insufficiency associated, this condition has not been considered a basis for rejection. There has been no instance in which this has been the cause of absence or complaint to my knowledge.

Arteriosclerosis and Myocardial Disease.—The degree of pathology and impaired physiology is difficult to determine from an objective examination. If there is no evidence of gross disturbance, employment has been allowed. In this group of older individuals, physical breakdowns are occurring more frequently. Two deaths from myocardial failure have occurred. The number of employees in this group are increasing rapidly.

Coronary Artery Occlusion.—There have been six cases of coronary thrombosis, with two deaths from this cause. The youngest is a male 29 years and the oldest a male 64 years. These types of cardiovascular disease offer industry a big headache. Conditions indicate it will become more acute before it improves.

Varicose Veins.—The existence of moderate or severe varicosities is a basis for rejection. In many instances the individual has had venesectory or injection treatment and has then been employed. Male employees seldom make complaints because of varicosities. All complaints to date have been made by female employees.

Herniae.—Smaller herniae, retainable by a prosthetic appliance, have been accepted. There has been only one instance where an individual so employed has offered any complaint. The individual coming from a sedentary job and older men who have relaxed inguinal rings are the source of trouble. There is an average of five to six cases of hernia reported each week. There are sixteen cases of females complaining of herniae. Two of these have inguinal, three have femoral, six have umbilical, and four have ventral herniae. One man, age 43, presented himself for employment with a postoperative ventral hernia, incarcerated, which contained at least three-fifths of his intestinal tract. He was not employed.

Pelvic Disorders.—Cystocele rates as the number one problem, inasmuch as the individual disclaims any symptoms until after employment. The increased physical effort soon causes the employee to report because of frequency of urination and prolapsus. Frequently incontinence is the complaint. In several cases, absence has been due to the employee seeking surgical repair of the neglected disability. When the cystocele is large, or moderately large, rejection is in order until repair has been effected.

Fibroid and ovarian tumors are the basis for rejection until removal has been effected. The percentage in the older group of female employees has been approximately 2 per cent. The youngest individual found to have a fibroid tumor was 22 years old. Operation was performed and she was subsequently employed. Four instances of carcinoma of the cervix have occurred.

Pelvic inflammatory conditions are found frequently in younger females. This has become a major problem.

Pregnancy is a basis for rejection and, after two months if employed, for resignation.

Dermatoses.—Applicants having demonstrable skin lesions are closely scrutinized. Rejections for this group are not numerous. A seborrheic diathesis seems to be the background for a large number of acute dermatoses developing after employment. Psoriasis has not been considered a basis for rejection. The occurrence of contact dermatitis after employment has become enough of a problem that a special dermatologic clinic is kept busy.

Bone and Joint Lesions.—When the physical examination or personal history indicates any lesion involving a bone or joint, an orthopedic and roentgenologic examination is made. Osteomyelitis, if not entirely asymptomatic and when the lesion is anatomically located where trauma may occur, is a basis for rejection. There have been several instances of rejection for osteomyelitis. These routine studies have revealed two instances of myelomata, one of osteogenic sarcoma, and three of osteitis fibrosa cystica.

Numerous instances of unknown fractures have been demonstrated. One case in particular is interesting because employment was granted where the history indicated an open reduction two years previously for fracture of the right radius. Three months later the employee reported because of a flexion deformity of 60 degrees. Examination revealed an ununited fracture, with evidence of wire-binding, metal plate and screws, and also bone graft. This individual then admitted three previous operations.

Arthritis, especially of the spinal column, is a major problem because of the feature of aggravation and prolongation of relatively minor injuries. These are usually found after the individual is employed. Similarly mechanically weak spinal structures with anomalous vertebrae are numerous. Spondylolisthesis, sacralization of vertebra, narrowing of intervertebral discs, old compression fractures and prolapsus nucleosus pulposa have all been revealed in several instances. More often than is desired, these individuals have been accorded employment before the true nature of their disability is apparent.

Venereal Diseases.—There have only been three cases of acute gonorrhea for which employment was refused. One instance of rejection for a primary luetic lesion is recorded.

A study of the laboratory records for the past eleven months reveals positive Kahn blood tests averaging 0.97 per cent to 1.4 per cent for males, and 0.4 per cent to 2.4 per cent for females. For all colored individuals the percentage range was from 8 per cent to 19.0 per cent. The mean average for white males was .99 per cent, white females 1.6 per cent, and all colored people 11.56 per cent. The mean average of positive urinary albumin was .02, per cent and glycosuria from al! causes .01 per cent.

Blood Dyscrasias.—A comparative survey of hemoglobin determinations for over one thousand applicants was made for the purpose of ascertaining if there was a lower average for Southern California residents. All ages and both sexes were considered. The only factor used was whether the individual had lived in California for more or less than one year. Those individuals having less than one year's residence were charted as to geographic origin. Thirty-nine States, representing all major sections of the United States, Canada, and Hawaii, are represented.

The Sahli method of hemoglobin determination was used.

The mean average of hemoglobin per cent for residents of California for over one year was 90.01 per cent and for those who have resided in the State less than one year, 91.4 per cent. The mean average for States in the deep South was 85.02 per cent, and for the northern states and Canada was 93.03 per cent. Hemoglobin determinations of 100 per cent were comparatively rare in this series.

Numerous instances of secondary anemia were found. There were three rejections for leukemia and two for pernicious anemia.

Chest X-Rays.—This is a subject for a separate report, and space in this article will only allow mention of some of the highlights.

Of the several thousand chest x-rays taken during 1942, the percentage of rejections for abnormal roentgenographic conditions was .018 per cent. There were .01 per cent of applicants who were employed with certain qualifications and who are rechecked at specified intervals.

The majority of the individuals rejected revealed evidence of pulmonary tuberculosis without calcific changes. The incidence of pulmonary fibrosis of a moderate to severe degree, where the second and third zones were particularly involved, was so frequent that 80 per cent is a fair estimate. In the first six months of 1942, over 22 per cent of chest plates revealed evidence of healed pulmonary tuberculosis, while the last six months revealed 48 per cent. This later period had over twice as many persons represented. This represents the period of greatest influx from other areas. These individuals, for the most part, also represent the lower income groups from other states.

There have been four cases of active pulmonary tuberculosis hospitalized in the past six months. Time will tell the rest of this story. We have no record of the percentage of positive cases in the group rejected.

Under the part-time employment plan, high school students are being employed. There have been several hundred of these 'teen-age individuals put to work. In this group, one would expect to find the largest group of normal plates. The majority of the plates taken so far reveal the picture of heavy peribronchial infiltration with numerous instances of calcific changes. More study is being accorded this subject.

Numerous anomalies have been noted in these routine plates. There were thirty-three instances of unilateral, and twenty-four instances of bilateral cervical ribs recorded in 16,500 plates. Several times diaphragmatic hernia, eventration of the diaphragm, and mediastinal neoplasms have been found. Bronchiectasis and bullous emphysema have been noted.

There is one case of carcinoma of the lung which occurred after the individual was employed, which was followed to a lethal termination.

IN CONCLUSION

Industrial organizations today are facing an increasingly grave situation with reference to potential illness. The medical organization of the whole community must realize their responsibility in this task. Upon them, to an increasingly greater degree, will fall the burden of helping keep workers on the job and to lessen the hours of lost production. We shall do our share toward this end, but we who are dealing directly with the problem recognize the need for the fullest coöperation of the entire medical fraternity.

Douglas Aircraft Corporation.

CHEMOTHERAPY: ITS RÔLE IN TRAUMATIC SURGERY*

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THE value placed upon chemotherapeutic agents by the medical profession in general, and by the habitually skeptical surgeons in particular, has been stepped up to a high intensity in the past few years; in fact, an intensity it had not experienced since the days of Galen. There are many reasons why it should be so highly regarded, and even some of our notions about "surgical principles" will have to be revised. However, there is still plenty of opportunity for the exercise of good judgment and common sense.

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The opinions or assertions contained therein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

SULFONAMIDE GROUP

The use of the sulfonamide group of drugs for topical administration in surgery got off to a slow start due to the poor results experienced in treating walled-off pyogenic infections. Although it is not entirely understood, it seems that the mode of action of the sulfonamide group is to render the various tissue fluids unfavorable as a medium for supporting the active multiplication of susceptible bacteria. To obtain this effect they must be in a sufficiently high concentration, and as they are relatively insoluble substances special conditions for their action must exist. In addition to the difficulty of insolubility there can be added the facts that the substances are broken down to form acetanilid in the tissues, and a certain proportion of the drug is bound to protein in such a way as to render it inert as a bacteriostatic factor. Of the various products now commonly in use, sulfanilamide is more soluble and less likely to combine with protein. In a bulletin issued in April, 1942, by the Bureau of Medicine and Surgery of the Navy Department it is recommended that only crystalline sulfanilamide be used for topical administration, and that sulfapyridine, sulfathiazole, and the other members of the group, be used by the oral and parenteral routes. One of the chief reasons for avoiding the implantation of sulfathiazole into wounds is the tendency of the particles to coalesce and form a foreign body. Since sulfathiazole has a particular effectiveness against certain organisms, notably staphylococcus, it is especially desirable that it can be used, and the objection to its "caking" will probably now be overcome by the use of the new microcrystalline sulfathiazole, which is available as powder and as a 10 per cent aqueous isotonic suspension. So far this substance is limited to investigational use. It has been our practice at the Naval Hospital at Mare Island to use a fifty-fifty mixture of sulfanilamide and sulfathiazole in its original form, and to attempt to overcome the difficulty of its acting as a foreign body by carefully spreading the material over the surface of the wound with the gloved finger in order to make a thin layer of the suspension against the wound edges.

Before making such an application it is important to do either a debridement of the wound or an entirely different procedure, complete wound excision. Since many of the wounds successfully treated with sulfonamide drugs are open infected wounds, often involving large areas, it is necessary to do frequent debridements. This means the removal of sloughs, coagulated exudate, dried pus, and the remains of tan. This can be accomplished by saline baths, by gentle mechanical removal, or by the application of starchy or gelatinous dressings to soften and facilitate the removal of such material. After this is done, the surface to be treated is lightly "frosted" with the crystalline material, either from a shaker container or by means of a powder blower. As the drug acts by going into solution in the media in which the organisms grow, it is necessary that the wound be kept moist, while at the same time avoiding excessive moisture which would wash away the sulfonamide. One way of doing this is to overlay the wound with strips of gauze which have been impregnated with an ointment, and thereby cut down evaporation and prevent drying and crusting, or to spray the wound with a combination of waxes and oils kept above its melting point in a "flit gun." Such a combination of paraffine, petrolatum, and liquid petrolatum, together with cod-liver oil, essential aromatic oils, and containing some sulfanilamide powder in suspension, has been used with success by naval surgeons in the treatment of the extensive burns sustained at Pearl Harbor on December 7, 1941. It was a natural step to use this material as a protective covering to keep moisture on areas frosted with the "sulfa" drugs. Colebrook and Francis (*Lancet,* March 1, 1941, page 271) found that when a second dressing was done where sulfanilamide was used, all the frosting had dissolved after twenty-four hours; but where sulfathiazole was used some of the material was still undissolved after twenty-four hours, but had all dissolved by forty-eight hours.

In line with the principles of debridement of wounds before using these agents, the use of hydrogen peroxide and other oxidizing agents to remove films of detritus, which would tend to render the drug inert, have been successfully tried. The presence of peptone-like substances from tissue disintegration have a neutralizing effect on the sulfonamide drugs. On the other hand, tissue breakdown is counteracted because the drug keeps down the growth of organisms. Thus, in the case of sulfanilamide, at least, it is possible to get concentrations in the fluids of wounds a hundred times as strong as can be obtained in the blood after therapeutic doses. In addition to the favorable effect of oxidizing agents before the reimplantation of the crystals, we find that chlorine-delivering substances have a particularly helpful effect. At Mare Island Naval Hospital we use the Council-accepted azochloramide, but any other relatively stable chlorine substances would be suitable. An aid in introducing sulfonamide substances into cavities is to apply the crystals to saline-soaked gauze packing, a procedure which could also be carried out in the preparation of skin areas around penetrating and perforating wounds at the time they are first seen.

COMMENT

With the addition of these chemotherapeutic agents to our armamentarium we are enabled to revise our ideas of the treatment of wounds, particularly with regard to the all-important lapsed time factor. As I stated before, common sense and judgment must not be set aside, but certainly we can safely undertake procedures on wounds much later than was formerly thought to be the case. At Mare Island Hospital we treated one patient who had an extensive tendon injury on the dorsum of his forearm. For various reasons, treatment was delayed for a period of about eighteen hours. Ordinarily no effort would have been made to do a tendon repair on such a patient, but in this case, with the liberal use of a fifty-fifty mixture of sulfanilamide and sulfathiazole powder, a complete repair was made with nonabsorbable suture and the wound proceeded to a complete recovery.

Compound fractures have been treated with more than ordinary success under battle conditions by merely excising the necrotic material, irrigating with saline solution, insufflating or otherwise instilling sulfanilamide crystals, packing open with vaseline gauze, immobilizing with plaster if feasible, and transporting to wherever definitive treatment was to be carried out. At Mare Island Naval Hospital we received many such patients on Christmas Day who were so managed after the December 7 attack at Pearl Harbor. It is contemplated that men going into combat will be provided with tablets for oral use, and that first-aid dressing stations everywhere will have ample supplies of the powder for topical use. There is considerable difference of opinion as to the amount of the substance which can be used at one time. In general, it seems that five grams in one wound, and a total of not more than ten grams in all wounds, seem to be a safe rule, although larger amounts have been used successfully. The best results come from a uniform light application to all the surfaces of a wound rather than the presence of large masses of the substance, which act as foreign bodies or are ejected unused. The sulfonamide group of drugs has been used in the treatment of all types of war wounds, bones, soft tissue, and wounds of the abdominal and thoracic viscera, both primarily and secondarily. Dr. Emile Holman, who is chief of the surgery service at the Mare Island Naval Hospital, has removed two foreign bodies embedded in the cardiac muscle, and after the extraction of these slugs we implanted the sulfanilamide sulfathiazole mixture in the cavities thus created.

At the present time* we have employed only sulfanilamide and sulfathiazole in the management of wounds, and have also used them freely in cases which are not traumatic, where we have reason to suspect or particularly fear infection. Sulfadiazine has been employed only in the treatment of burns, using a 3 per cent solution in 8 per cent triethanolamine, as suggested by K. L. Pickerell in the bulletin of the Johns Hopkins Hospital, 69:217 (August, 1941). This seems promising, but our own experiences are as yet quite limited. Sulfapyradine has not been used by us for local administration. There are already many more sulfa compounds in various stages of investigation and, doubtless, more to come, some of which will probably be demonstrated to have superiority in different ways.

It is highly desirable that sulfonamide compounds be sterilized for topical use. Exposure to dry heat for two hours at a temperature of 150 degrees Fahrenheit seems to be satisfactory. Transfer from large to smaller packages must be made with sterile precautions.

PEROXIDES

Another group of substances which are finding new and wide application in traumatic surgery are the peroxides. This is particularly true of the peroxides which give off oxygen slowly and continuously under special conditions, such as zinc and benzoyl peroxide. Considerable experience and literature have accumulated on the use of zinc peroxide in wounds where members of the genus Clostridium and other anerobes are likely to be found. A 40 per cent aqueous suspension is applied to the wound surfaces and crevices after debridement, and arrangements made to keep moisture supplied, as this is necessary for the liberation of oxygen. Benzoyl peroxide seems to be particularly effective in the promotion of healing of surface wounds, and has the added advantage of a mild anesthetic effect. It can be used either as powder, a 10 per cent aqueous suspension, or in an ointment base. Both zinc and benzoyl peroxide can be used in combination with sulfonamides, either applied locally or given by one of the other available routes.

CHLORINE-PRODUCING SUBSTANCES

I have already mentioned the chlorine-producing substances in connection with sulfonamide therapy as an adjunct to surgery. Many of you, no doubt, remember the tedious Dakin treatments developed during the last war. We now have more stable and simpler chlorine-delivering substances in common usage. Chloramine-T and dichloramine-T are available under several trade names. At the present time, at Mare Island Naval Hospital, we are using azochloramid, which has been accepted by the Council on Pharmacy and Chemistry of the American Medical Association. It is employed in isotonic buffered saline solution of 1:3300, which we use for irrigating wounds, and 1:500 in glyceryl triacetate, which we instill into wounds or apply as wet dressings. These dressings are not particularly uncomfortable, and the preparation is stable and definitely effective.

BURN THERAPY

The subject of burn therapy is being covered in other papers presented at this meeting, and it seems best only to mention a few brief points. Tannic acid in its various forms, either alone or in combination with other substances such as silver nitrate, has limited applications, but is unsuitable in general on the face, hands, genitalia, or where there are encircling burns of extremities. Triple dye has its proponents and a special field of usefulness, probably for the most part in conjunction with other materials in certain stages of burn-healing. We received a large number of burns as a result of the Pearl Harbor disaster, but by the time we began their treatment they could be considered more as large open wounds than as burns. They had been treated in various ways at the start. One follow-up treatment which has been employed at Mare Island is the use of a wax and oil spray into which sulfanilamide, cod-liver oil, menthol, camphor, and eucalyptol have been incorporated. This is kept hot in a water-bath and applied with a spray gun, and the patients kept in the open air without dressing, warmth being provided by cradles and lights. They are allowed to take shower baths and the wax mixture is frequently reapplied.

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* May, 1942.

IRRIGATION SOLUTIONS

Another class of substances is that used for the cleansing of skin and the debridement of wounds. For irrigation in wounds we have used mainly saline solution, although potassium permanganate, in strength varying from 1 : 2000 to 1 : 5000, is suitable. We have not employed iodine or the mercuri-cresol preparations, such as merthiolate or metaphen, in wounds involving deep structures, tendons, and bones. Tincture of green soap, either alone or with hydrogen peroxide, is suitable only in the more superficial types of wounds. Skin preparation and cleansing is done usually with mercuri-cresols, and penetrating wounds and compound fracture wounds are lightly plugged, while this is being done to prevent the entrance of these substances into the wound. Where adhesive is to be applied, we usually use merthiolate and then paint the surface with a second coating, using tincture of benzoin.

COMMENT

As has already been stated, the sulfonamides act by inhibiting growth-promoting factors, such as para-aminobenzoic acid. After continued use this may also inhibit cellular growth in the tissue of the animal being treated. Several investigators have found that this can be overcome to a great extent by the application of substances such as allantoin, or 50 per cent urea solution, or benzyl peroxide. Allantoin can be incorporated in an ointment base in 2 per cent strength, along with benzoyl peroxide 10 per cent strength. The use of cod-liver oil also counteracts the tendency to depress the growth of cells.

Perhaps one should not leave the subject of sulfonamide drugs without mentioning toxic reactions, especially since our topical administration is usually augmented by giving the drug orally, intravenously, subcutaneously, or occasionally rectally. We have had numerous cases where a diffuse (often a scarletiniform) rash appears. In only one case, however, did we have the rash where the drug was not used in any other manner than locally. We have had several cases which, after the subsidence of fever, developed a high elevation of temperature, and others where there was a diminished urinary output with red blood cells and crystals. We immediately stopped the drug in such cases, and saw no further ill effects. There has been a very small number of cases where the ability to form white cells has been impaired in the group which we have treated.

SUMMARY

Since the last world war many new chemotherapeutic agents have come into use as adjuncts to surgery in treating traumatic wounds. Most notable among these are the sulfonamides, where, with local application, we can obtain high concentrations at the site where they will be expected to accomplish the most good. This can be made a generalized feature of first-aid under combat conditions to reduce the danger of infection until definitive treatment can be instituted. The stable peroxides offer a weapon to combat anerobic infection, and the more stable chloramine substances provide a readily available means of keeping down wound infection by the liberation of chlorine.

Mare Island Hospital.

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LARGE VESICAL CALCULUS IN ASSOCIATION WITH GIGANTISM

Earl F. Nation, M. D.
Pasadena

The case here reported is of interest because of the large size of the bladder calculus and because of its occurrence in a patient afflicted with gigantism. The latter is of speculative etiological interest.

REPORT OF CASE

The patient, T. C., a 33-year-old caucasian male laborer, entered the hospital on March 22, 1943, complaining of chills and fever of nine days' duration, with associated urinary frequency and dysuria. He had suffered several similar, although milder, attacks since the first in 1935.

Family History.—Patient's father and mother, who were apparently normal, died of influenza in 1917. There were no siblings.

Past History.—Normal, healthy childhood until the age of eighteen, when he had an osteomyelitis of the left tibia which drained for a year. It was at about this age that the patient began to grow more rapidly than theretofore. Growth continued to the time of admission, his height having increased one-half inch during the past year. Hat, glove, and shoe sizes had increased gradually. Had always had moderate polydypsia. Libido and potency always subnormal and recently diminishing. Had never had to shave more often than every four to seven days. About ten years ago his left breast swelled to the size of an egg and remained tender for a long time.

Physical Examination.—Height 76½ inches, weight 190 pounds, temperature 101.6, pulse 88, respiration 24. The patient was an acutely ill, shy, prognathous individual with wiry hair and small, close-set eyes. The supra-orbital ridges were very greatly enlarged. The hands and feet were large and there was an excessive accumulation of fat about the hips. His physique was otherwise normal. There was no apparent restriction of visual fields present. The heart and lungs were normal. Blood pressure, 110/75. Breasts normal. There was generalized distention of the abdomen and moderate suprapubic tenderness. The penis measured about 6 centimeters in length and 2 centimeters in diameter when stretched. There was moderate phimosis. The testes were soft and infantile, measuring approximately 1.5 centimeter in length. The distribution of pubic hair was essentially masculine. The prostate was boggy, but seemed to be of average size.

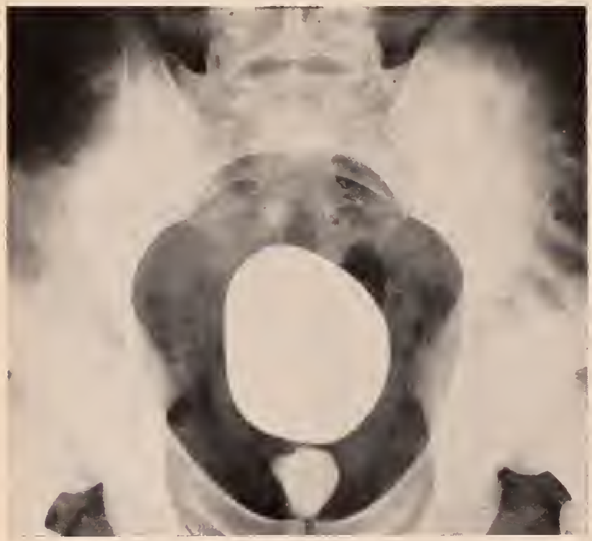

Fig. 1.—Plain x-ray picture of the pelvis showing calculi.

Laboratory Data.—Urinalysis, p^H 6.5; specific gravity, 1.011; albumin, 2 plus; sugar and acetone negative; pus, 4 plus; red blood cells occasional; numerous Gram-negative bacilli and Gram-positive cocci. Blood count: red blood cells, 3,920,000; hemoglobin, 76 per cent; white blood cells, 9,550; neutrophils, 84 per cent; segmented forms, 71 per cent; stabs, 13 per cent; eosinophils, 1 per cent; and lymphocytes, 15 per cent. Hinton and Kahn were negative. NPN three days after admission 48.5 mgms. and two days later 46 mgms. Serum calcium on March 27 was 9.6 mgms. and phosphorus 3.5 mgms., and on April 12 the calcium was 9.9 mgms. and phosphorus 3.5 mgms. The preoperative PSP test was: first hour no dye, second hour 8 per cent, and third hour 5 per cent. Three weeks after operation the PSP test was: first hour 8 per cent, second hour 30 per cent, and third hour 10 per cent.

A KUB x-ray picture was taken on March 25, showing an 8 by 10 centimeter stone shadow in the bladder region and an irregular stone shadow 3.3 centimeters in diameter below this (Fig. 1). Excretory urograms taken the same day showed no dye excretion in three hours. A cystogram taken the following day with three ounces of sodium iodide showed an irregular bladder filled by stone. There was reflux of media up a greatly dilated left ureter. X-rays of the sella turcica showed it to be large, but regular.

Cystoscopic examination was made on March 28 under intravenous sodium pentothal anesthesia. There were 20 cubic centimeters of cloudy residual urine. The only urethral obstruction was at the vesical neck, where an irregular stone was impacted in a pocket at the base of the bladder. This was dislodged with the beak of the cystoscope and the right ureteral orifice was seen to open beneath it and to be enlarged. The left was less enlarged. The bladder was filled with a large, smooth calculus.

Operation.—Cystolithotomy was performed on March 31. An effort was first made to engage and deliver the stone with obstetrical forceps according to the method of Crance.[1] However, the stone was not quite large enough to make this practicable and it was finally delivered manually. A de Pezzar catheter was left in the bladder. The large calculus measured 7.2 by 5.5 by 4.4 centimeters, was gray-pink in color and weighed 255 grams. The small one measured 2 by 2.2 by 0.8 centimeters and weighed 30 grams (Fig. 2). The large stone was sectioned and no foreign body nidus found. It obviously was composed largely of calcium salts.

There was very little postsurgical reaction. The patient was out of bed after the second postoperative day. The suprapubic catheter was removed on the tenth postoperative day and the wound was dry and the patient voiding freely a week later. On the twenty-second postoperative day the patient was planning to go home, when he was found lying across the bed perspiring freely, cyanotic, and very restless. He died one hour and fifteen minutes later.

Autopsy.—The coroner did a postmortem examination, but unfortunately failed to open the head. The essential findings were massive pulmonary embolism and extreme bilateral hydronephrosis and hydroureter. The endocrine glands were examined only grossly.

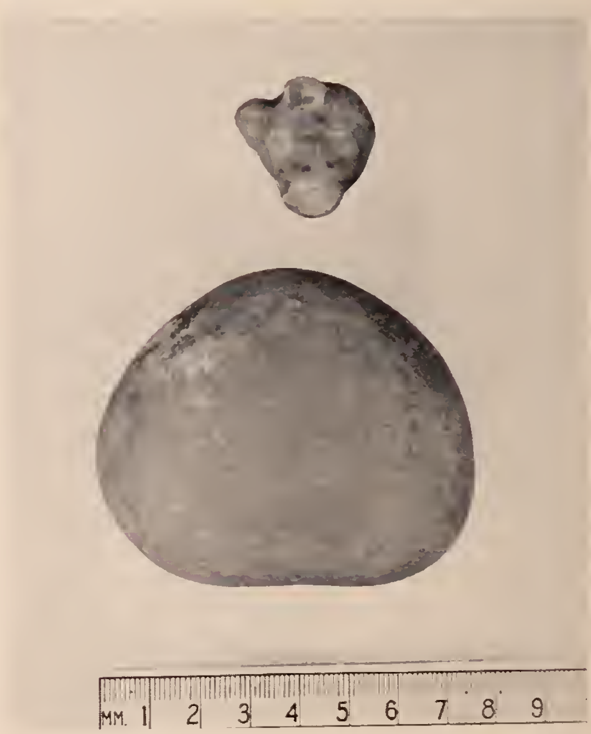

Fig. 2.—Calculi removed from the bladder.

DISCUSSION

The size of the calculus removed from this patient, while very unusual, is not rare. A number as large, and larger, have been described. That reported by Alexander Randall[2] remains the largest on record. Crance,[1] in reporting a giant calculus, reviewed most of those previously recorded.

The nature of the etiology of a stone of such great size in an individual the age of this patient is intriguing. There was no apparent nutritional deficiency, nor was there any urinary tract obstruction to explain the calculus formation. Whether the urinary tract infection was primary or secondary is conjectural, but there must certainly have been an associated disturbance in calcium metabolism in this case.

The patient would seem to have had a mixed endocrine dyscrasia. There were elements of simple hypogonadism, but there was also unmistakable hyperpituitarism, and the latter was perhaps the primary condition.

Both the gonads and the gonadotropic hormones of the anterior pituitary have been shown to be concerned intimately with calcium metabolism by Riddle and Dotti.[3] These workers showed that adequate and sufficiently prolonged administration of gonad stimulating hormone of the anterior pituitary results in an increase of serum calcium in animals. This action was found apparently to be exerted on tissues producing sex hormone or chemically related substance. They did not determine the part played, if any, by the parathyroid glands in this action. Certain female hormones, notably theelin, were found to be very active in raising the serum calcium in normal, castrated, hypophysectomized, and thyroidectomized animals, whereas testosterone had no such action. The hypogonadism and hyperpituitarism of the patient under consideration may thus have resulted in a disturbance of calcium metabolism with resultant stone formation.

There is still uncertainty about whether the parathyroid glands are stimulated by the pituitary. Considerable evidence has been adduced to suggest such a relationship.[4,5,6] If this is true, hyperpituitary patients would seem to be candidates for stone in view of the well-known association of hyperparathyroidism and nephrolithiasis.[7,8] No reports could be found of other cases of the concurrence of hyperpituitarism and urolithiasis. Perhaps the latter should be looked for more carefully in such patients.

The calcium and phosphorus values in the case reported here, being essentially normal, raise some doubt of the presence of hyperparathyroidism or disturbance of calcium metabolism. Barney and Mintz [8] state that serum calcium and phosphorus values, to be definitely suggestive of hyperparathyroidism, should be above 11 mgms. and below 3.5 milligrams, respectively. However, Albright, Aub, and Bauer [6] note that the calcium and phosphorus values may be less abnormal with failing renal function, which could account for the lack of deviation in this patient.

Thus, while no definite conclusions can be drawn from this particular case it does suggest some possible clinical significance of the disturbance of the normal calcium metabolism produced by pituitary and gonadal dyscrasias or the prolonged administration of their hormones.

SUMMARY

A giant vesical calculus removed from an individual with gigantism and acromegaly is reported and the possible etiological relationship discussed.

112 North Madison Avenue.

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MEDICAL EPONYM

Foramen of Winslow

This entity was described by Jacques-Bénigne Winslow (1669-1760) in *Exposition anatomique de la structure du corps humain* [*An Anatomical Exposition of the Structure of the Human Body*] (Paris, 1732). The following quotation appears on pages 171 and 172 of the second volume of the English translation by G. Douglas (London, 1743):

"We see from this situation of the two omenta that, in the space left between the lower side of the stomach and upper side of the mesocolon, they have a very broad communication with each other; so that if either of them contained in its cavity any fluid, that fluid might readily get between the stomach and mesocolon and so pass into the other bag; especially when the stomach is empty and consequently its situation easily changed.

"Therefore, by means of this interstice between the stomach and mesocolon, the two omenta form one cavity, which opens into the cavity of the abdomen by one common orifice situated near the commissure on the right side of the great omentum. This orifice is semilunar or semicircular, and formed by the union of two membranous ligaments, whereof one connects the beginning of the duodenum and neck of the vesicula fellis to the liver; the other connects the contiguous portion of the colon to the same viscus, and extends to the pancreas. From thence arises an incurvated border which surrounds the root of the lobulus, leaving an opening wide enough to admit the end of the finger.

"To discover this orifice of the omentum, we need only raise a little the great lobe of the liver and find out the root of the lobulus and apply to it a large pipe wrapt round with cotton, wool or tow, to hinder the regress of the air. Then if we blow gradually, the air will inflate the sides of the great omentum and give it the appearance of a large bladder irregularly divided into several lobes or tubercles by the bands of fat which appear in this state like so many fraena between the lobes."—R. W. B., in *New England Journal of Medicine.*

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL NOTICES

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred and Twelfth (312th) Meeting of the Council of the California Medical Association*

The meeting was called to order in Room 210 of the Hotel Sir Francis Drake, in San Francisco, at 10:30 a. m., on Sunday, August 22, 1943.

1. Roll Call:

Councilors present: Philip K. Gilman, Chairman; William R. Molony, Sr., E. Vincent Askey, E. Earl Moody, Edward B. Dewey, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Calvert L. Emmons, Harry E. Henderson, Axcel E. Anderson, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, Donald Cass, and Secretary George H. Kress.

Councilors absent: Karl L. Schaupp, Lowell S. Goin (out of State), and R. Stanley Kneeshaw.

Present by invitation: L. A. Alesen, Vice-Speaker; Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; Mr. John Hunton, Executive Secretary; Mr. Hartley F. Peart, Legal Counsel; Mr Howard Hassard, Associate Legal Counsel, Mr. Ben Read, Secretary, California Public Health League; Clifford W. Mack, President, Association of California Hospitals; Anthony J. J. Rourke, member of Board of Trustees of Association of California Hospitals; T. Henshaw Kelly, member California Physicians' Service Board of Trustees; A. E. Larsen, Secretary of California Physicians' Service; and Mr. W. G. Ebersole of California Physicians' Service.

2. Minutes.

(*a*) Minutes of the 311th meeting of the Council, held on June 19, 1943, in San Francisco, were submitted and approved. (Minutes printed in CALIFORNIA AND WESTERN MEDICINE, July, 1943, pages 71-77.)

(*b*) Mail ballots were approved as follows:

Ballot of July 31, decision being in favor of San Francisco for the August 22 meeting; and ballot of August 6, the decision being in favor of the recommendations made in the resolution adopted at the California Physicians' Service and Housing Authority meeting of July 28, 1943, regarding possible financial supplements to tenants' dues for a continuation of California Physicians' Service in Federal housing areas; the decision also being in favor of tenants' participation in California Physicians' Service as a condition of occupancy in Federal housing areas.

3. Membership.

(*a*) A report of membership, as of August 20, 1943, was submitted and placed on file.

(*b*) On motion duly made and seconded, it was voted that membership of twenty-four members whose dues had been paid since the last Council meeting, held on June 19, 1943, be reinstated.

(*c*) Upon motion duly made and seconded, retired membership was granted to the following member, whose application had been received in duly accredited form from his respective county society: Ira B. Bartle, M. D., San Luis Obispo County.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

4. Financial:

(*a*) Reports of finances were submitted by the Executive Secretary and placed on file:

Cash report, as of August 20, 1943:

Income account for August and for eight months;

Balance sheet, as of July 31, 1943.

(*b*) It was voted to let the maximum amount in the Revolving Fund be $2,250, this action being necessary because of the new Federal income tax and wage deduction drafts on that fund.

(*c*) It was voted that $15,000 be transferred from the general funds as a payment on the loan made by the Trustees Of The California Medical Association to the California Medical Association.

5. Federal Children's Bureau Maternity-Pediatric Plan:

(*a*) General discussion concerning the federal Children's Bureau maternity-pediatric plan took place.

It was agreed that there was no reason to change the outline of procedure as given in the letter dated July 1, 1943, which was sent to the component county societies by Council Chairman Gilman, and printed in the July issue of California and Western Medicine, as Item XI, on page 83.

Attention was called to the statement received from the California State Board of Health that, when a physician contracted to accept obstetric or pediatric work under the federal Children's Bureau plan, the physician under the regulations put forth by the Children's Bureau of the United States Department of Labor is not permitted to accept the payment from the California State Board of Public Health—acting for the federal Children's Bureau—and also accept an additional payment from the patient *for the same service.* However, for services to mother or child that are not included in the authorized schedules of the Children's Bureau, payments therefor may be made by the patient.

(*b*) Councilor Kindall called attention to problems which had caused discussion among attending staff members in some of the county hospitals when the institutions accepted payments for professional services rendered by nonindigent patients, the same being then placed in a separate fund; the money so received for such professional services being used under certain conditions for the purchase of additional equipment, etc. It was agreed that Councilor Kindall and Legal Counsel Peart should confer concerning the issue involved and submit a report to the Council.

6. Osteopathy in California:

General discussion took place concerning the proposals that had been communicated to members of the Council by some osteopathic physicians and surgeons.

It was agreed that a committee, consisting of Doctors Cline and Dewey, and Mr. Peart, be appointed to draft a resolution in which would be incorporated matters upon which the Council had come to agreement. The following resolution was submitted and adopted:

Whereas, The Council of the California Medical Association has been informed that representatives of the California State Osteopathic Association have conferred with representatives of the California Medical Association concerning plans whereby osteopathic physicians and surgeons might secure additional training leading to the degree of M. D.; and

Whereas, The representatives of the California State Osteopathic Association in conference have expressed their intention to:

(*a*) Repeal the existing osteopathic initiative;

(*b*) Terminate the existence of the College of Osteopathy in Los Angeles, as a college of osteopathy, and make its facilities available to an acceptable university for medical teaching; and

(*c*) Conclude arrangements with a university to offer a special curriculum to which an osteopathic physician and surgeon, or a student or intern at the time of consummation of such plans, may be admitted; such person to receive the degree of M. D. upon satisfactory completion of the course; and

Whereas, It appears to the Council of the California Medical Association that it would be in the public interest to include the osteopathic physicians and surgeons of California with the Doctors of Medicine of California; therefore, be it

Resolved, That the Council of the California Medical Association approves of the foregoing plan to facilitate the merging of the osteopathic physicians and surgeons with the doctors of medicine of California; and be it

Resolved, That the Council of the California Medical Association, upon fulfillment by the California State Osteopathic Association of the intentions herein outlined, will recommend that its component county societies open membership, in the usual manner, to those osteopathic physicians and surgeons who have achieved the degree of M. D. under this program, and associate membership to the osteopathic physicians and surgeons who have licenses in good standing; and be it further

Resolved, That the Council of the California Medical Association will undertake to obtain approval of this program by the Council on Medical Education of the American Medical Association and the Association of American Medical Colleges.

7. Federal Housing Projects:

Medical service conditions which had arisen in Federal Housing Projects were discussed, with particular reference to the situations which had come into being in San Diego County when California Physicians' Service served notice upon the local Housing Authorities that California Physicians' Service found itself obliged to withdraw from the work, since the income received made possible only the payment of a small fraction of the nominal unit value that had been designated for professional services.

In the discussion, Councilor McClendon, Dr. T. Henshaw Kelly of the Trustees of California Physicians' Service, Dr. A. E. Larsen, Executive Medical Secretary of California Physicians' Service, Councilor Green of Vallejo, and other councilors took part.

Doctor Kelly called attention, whereas, in 1942, the birth rate per thousand population was 17.2, that in 1943 it had become 22.0 per thousand; but that in the housing areas it had become 100.0 per thousand, and this obstetric service had become the largest single item in the matter of medical care and costs in these housing areas, so that the nominal unit value of $2.50 to compensate for professional services had been reduced to 25 per cent of its value. Further, that the cost of the obstetrical care rendered in the housing areas had amounted to 40 per cent of the entire income received to cover all forms of medical service.

It was desirable, therefore, that the federal Housing Authorities give to local Housing Authorities permission to sign contracts and to pay California Physicians' Service direct, and also to collect the monies agreed upon for medical care coverage in such manner as might be deemed best.

It was pointed out that the Linda Vista Housing Project in San Diego was the first contract made and that it was necessarily experimental. The medical service in the housing projects, in one sense, had been thrust upon California Physicians' Service because the rapid increase in population in war production areas situated in San Diego, Vallejo, and other places made it possible for the local profession to meet the demands for medical care in only a partial manner. The thought was expressed that some governmental authorities seemed less concerned with maintenance of the quality of medical care, with proper cost coverage for professional services rendered, than they were with other features.

Doctor Green of Solano County outlined some of the problems which had arisen in the rapidly growing Vallejo area, referring to a letter of August 18, which he had written to the Executive Director of the Vallejo Housing Authority concerning a conference in which matters of mutual interest might be discussed.

Reference was made that the local Housing Authority had funds whereby compensation could have been paid to physicians for services rendered on a basis other than that of 20 cents on the dollar, but that the official red tape concerning such funds made it impossible for local housing officials to act. It was felt that a 50 per cent increase in rates might aid in solving the difficulties. The big loss was in the professional care of couples and families, and not in the care of single men. To secure full unit compensation for participating physicians, it seemed necessary to raise the rates for couples from $4 to $6 per month, and for a family of five to $7.50.

In problems of such magnitude and gravity, in which the health of war workers is involved, it certainly should be possible for the Federal authorities to provide procedures sufficiently elastic to permit at least nominal compensation for medical care of proper quality.

As regards many citizens who are in housing areas the statement was made that human nature is such that, in the matter of medical care, as with other needs, many citizens want as much as possible for as little as possible, and that it is difficult to make many of these citizens comprehend the basic costs of medical care that measures up to proper quality.

The minor illnesses are treated in the housing projects without special trouble, the project doctor also giving care to the two-visit deductible patients. In other words, the project doctor can do much initial work that would otherwise consume the time of members of the local profession who are busy in practice in the near-by cities.

The resolution of July 28, 1943, adopted at a meeting between representatives of the California Physicians' Service and the Federal Housing Authority, was read and, upon motion duly made and seconded, was adopted. Councilor S. J. McClendon requested his negative vote to be recorded. Resolution follows:

Resolved, That the Federal Public Housing Authority be requested to recognize the great need for medical care in housing projects in communities that cannot be provided for by any other means, and that the FPHA be requested to authorize local housing authorities to enter into such contracts with California Physicians' Service as may be necessary and desirable for insuring the continuation and extension of the C. P. S. program.

The Council was informed that representatives of California Physicians' Service and the local Housing Authorities were scheduled to leave for Washington on August 23 and that it would aid them in the presentation of the California problems if a resolution concerning the housing problems could be adopted.

After further discussion and upon motion duly made and seconded, it was voted that the following resolution be adopted:

Resolved, That the proper authorities in Washington be requested to put into operation the program outlined in the resolution adopted at the meeting of July 28, 1943, between California Physicians' Service and the Federal Public Housing Authority.

8. Medical Service and Hospitalization Survey: Mannix Report:

Councilor Cline, chairman of the special Liaison Committee on Medical-Hospitalization Services, stated he had requested Dr. Anthony J. J. Rourke of Stanford University Hospitals and a trustee of the Association of California Hospitals and a member of its Blue Cross Plan Committee, to appear before the Council and explain what had been done by the hospital groups.

Doctor Rourke informed the Council concerning the discussions and action taken by the Association of California Hospitals regarding the survey that had been made by Mr. John R. Mannix of the Michigan Medical Service concerning California medical and hospitalization groups. A report of a meeting of the Blue Cross Plan Committee, held on June 26, 1943, and a questionnaire in regard to the Mannix survey were read.

Doctor Rourke stated that the Board of Trustees of the Association of California Hospitals had approved the following recommendations:

"Your Committee recommends that, if 75 per cent of the beds in nongovernmental hospitals in California answer the above questionnaire in the affirmative, that your Committee be empowered to extend an invitation to Mr. Mannix to return to California for a short period of approximately a week to assist in the first steps in the proposed establishment of the state-wide plan recommended.

"In summary, your Committee recommends approval of the following:

1. The Mannix Survey.
2. Printing and distribution of the Mannix Survey.
3. Letter addressed to hospital trustees.
4. Questionnaire to hospital trustees.
5. Invitation to Mr. Mannix to revisit California.
6. Appropriation of funds to cover expenses of printing and mailing material to hospitals.
7. Appropriation of funds to cover expenses to be incurred by Mr. Mannix upon his return trip to California."

Doctor Rourke added that, in connection with this work, more than $4,000 had already been received from hospitals in California. The importance of prompt and clarifying action was indicated and in the discussion that followed this was further emphasized.

Several councilors spoke of the excellent manner in which the Association of California Hospitals had taken up the consideration of problems that were of mutual interest and complimented the Association upon progress it had already made.

Dr. T. Henshaw Kelly, a trustee of California Physicians' Service, stated that Doctor Rourke had presented the problems to California Physicians' Service and that Chairman Ray Lyman Wilbur had appointed a special committee, consisting of Doctors Kelly, Askey, and Kilgore, to make further study of the recommendations outlined in the Mannix report. California Physicians' Service Trustee Kelly stated that California Physicians' Service was willing to coöperate in the promotion of a joint medical-hospitalization service plan.

Some of the difficulties in bringing about a full coöperation were indicated. At the present time, California Physicians' Service is not making any full-coverage contracts, its two-visit deductible contracts having some 30,000 beneficiary members, and its surgical contracts a total of 20,000.

The importance of coöperation in matters of sales, acquisitions, collections, and public relations was emphasized.

Doctor Kelly stated that California Physicians' Service did not wish to be bound down to such extent that it could not carry out certain medical experiments which were construed by it to be important.

It was agreed that, if the unit value for professional services that had been rendered could be brought up to a 100 per cent basis, much of the criticism would disappear.

Councilor Cline stated it was important for the medical profession to coöperate as fully as possible with the Association of California Hospitals, in order that a more harmonious and efficient setup in medical service and hospitalization might be created in California than is now in operation.

On motion duly made and seconded, it was voted that the California Medical Association Committee, Doctor

Cline, chairman, be authorized to confer with the California Physicians' Service committee, consisting of Doctors Kelly, Askey, and Kilgore, in order to work out a program concerning objectives to be attained.

It was also voted that in due course Doctor Cline's committee should have power to have the survey report of Mr. John R. Mannix and the reports of the committees and the Council's actions in regard thereto, printed in California and Western Medicine.

9. Study of Public Relations:

E. Vincent Askey, Speaker of the California Medical Association House of Delegates, requested permission to outline a plan for the study of public relations, with special reference to the attitude of the public toward Organized Medicine as represented by the American Medical Association, the California Medical Association, and its component county societies.

Doctor Askey stated that, for reasons that it was not necessary to take up in detail, there was unquestionably a decided sentiment among a large group of citizens of the State which led them to be skeptical, opposed or antagonistic concerning the motives and objectives of Organized Medicine. If scientific medicine and medical service of proper quality are to be maintained, it is important for the medical profession to learn what is at fault in the existing set-up, and what has led to the changed attitude on the part of the public. He felt that the medical profession is largely to blame in not recognizing the conditions under which we are now living and that only great harm will come to medical practice and to the public health if changes are not instituted. He referred to conversations he had had with many lay persons. As an example of what could be done in bringing about a better understanding on the part of the public when erroneous impressions were existent, he cited the educational campaigns that have been carried on with success by some of the large corporations of America.

Doctor Askey felt that this line of work could not be conducted with any assurance of ultimate success if left to amateurs. He felt that it would be a wise expenditure of funds if the best possible talent could be secured: (1) to learn what is the attitude of the people of California concerning the medical profession through a cross-section survey of the State; and (2) if the information so acquired had appeal, it may be deemed advisable to follow the example of other large organizations in bringing about a change of opinion, even though the educational campaign might necessitate the expenditure of large sums of money.

Doctor Askey stated he had asked Mr. Ebersole of the California Physicians Service staff, who had had contacts with some of the large public relations firms, to give further information concerning possible costs. Mr. Ebersole related to the Council what he had learned in his conference.

Vice-Speaker Alesen took up the discussion, emphasizing the points brought out by Speaker Askey, stating that we were at the cross-roads, and must determine whether we shall adopt a defeatist attitude or decide upon a positive, constructive program. General discussion followed.

Upon motion duly made and seconded, it was voted that Council Chairman Gilman be authorized to appoint a committee of three members to make a further study of the suggestions presented by Speaker Askey, the committee to bring in a report to the Executive Committee and the Executive Committee to have power to act. (The committee appointed consists of Doctors Askey, Cline, and MacDonald.)

10. Public Policy and Legislation:

Dwight H. Murray, Chairman of the California Medical Association Committee on Public Policy and Legislation, spoke of the difficulties in securing adequate information concerning proposed legislation in Congress. He felt that the existing arrangements with the national organization are not working out in proper form and felt that it was desirable to approach the solution of the medical-political problems concerned with California, through some other agency.

After full discussion, it was voted that $250 be sent to the California State Chamber of Commerce to carry out the plans outlined by Doctor Murray. It was felt that the money would be wisely expended if it would permit the medical profession of California to have a better understanding of federal legislation than has been possible to obtain in the past.

11. "California and Western Medicine":

Secretary-Editor Kress called attention to the insert of supplement cards which had been sent out by the Ohio State Medical Association, as outlined in the editorial comment on page 109 of the August issue of the Official Journal. Upon motion duly made and seconded, it was voted that the editor be authorized to arrange for the printing and insertion of such a supplement card in an early issue of California and Western Medicine.

It was also agreed that the Association should print and offer for sale, at cost, insert slips that could be sent out with statements, in which the ways through which lay persons might aid in maintaining adequate medical service would be outlined.

12. Annual Session:

On motion duly made and seconded, it was voted that the annual session in 1944 be held in the city of San Francisco, war conditions permitting.

13. Fee Schedule:

Information concerning the proposed changes in the fee schedule of the California Industrial Accident Commission was given by Executive Secretary Hunton and Legal Counsel Peart, and the committee was authorized to take such further steps as may be deemed advisable.

14. Federal Wage and Hour Act:

A letter from the Medical Diagnostic Laboratory of Los Angeles was read regarding the governmental interpretation of what constitutes interstate commerce in relation to physicians, such as pathologists who make reports to doctors of medicine in different states. It was voted that the same be referred to the Legal Counsel of the Association.

15. Request From American College of Chest Physicians:

Request was made by the American College of Chest Physicians that the California Medical Association appoint a special committee on tuberculosis. It had been pointed out in the agenda that a standing Committee on Health and Public Instruction could appoint a subcommittee on tuberculosis, Chairman Gilman to send the necessary information to Dr. John Ruddock, chairman of the Committee on Health and Public Instruction.

16. Time and Place of Next Meeting:

It was voted that the next meeting be held in Los Angeles on Sunday, October 10.

17. Adjournment:

Philip K. Gilman, *Chairman*
George H. Kress, *Secretary*

Circles are praised, not that abound
In largeness, but the exactly round:
So life we praise that does excel
Not in much time, but acting well.
—Edmund Waller, *Long and Short Life.*

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

American Casualties Total More Than 100,000 to Date

Washington, Sept. 1 (AP).—More than 100,000 members of United States military forces and the merchant marine have been killed in action, wounded, reported missing, or taken prisoner.

The Army reported today that its casualty total through last week was 69,358. Navy casualties totaled 21,556, Marines 7,904, and Coast Guard 363. The latest merchant marine summary showed a total of 4,751 dead and missing. All these add up to 103,932.

However, the Army said that 8,748 of its men classed as wounded have left the hospital or returned to duty.

A total of 19,581 persons in all thirty-five services are listed as dead, and 35,895 are listed as missing, the total of those two figures being 55,476.

Following are the latest casualty summaries for the services:

Army (through the end of last week): killed, 8,927; wounded, 19,391, of whom 8,748 have left the hospital or returned to duty; missing, 21,406; prisoners of war, 19,634; total, 69,358.

Navy (to date): dead, 7,840; wounded, 2,553; missing, 8,917; prisoners of war, 2,246; total, 21,556.

Marines (to date): dead, 2,005; wounded, 2,501; missing, 663; prisoners of war, 1,925; total, 7,904.

Coast Guard (to date): dead, 182; wounded, 22; missing, 158; prisoner of war, 1; total, 363.

Merchant Marine (from September 27, 1941, to August 1, 1943): dead, 627; missing, 4,124; total, 4,751.—San Francisco *Chronicle*, September 2.

Army Rejects 27.8 Per Cent of Drafted Men

66,491 Out of 233,813 Californians Are Turned Down

Washington, August 26.—Selective Service statistics showed today that during twenty-six months of drafting men for the armed forces, 27.8 per cent of the 5,043,135 sent to induction stations were rejected as unfit, physically or otherwise.

The statistics, contained in the annual report of the Selective Service system, covered the period from the first inductions in 1940 through November 30, 1942.

The number rejected during the period was 1,400,840. Of these, 1,184,456 were whites, 26.6 per cent of the 4,451,692 forwarded to induction stations by draft boards. The Board sent 591,443 negroes and of these 216,384, or 36.6 per cent, were rejected.

California rejections were exactly the same as the national average. California sent 233,813 men to induction stations, of which 66,491, or 27.8 per cent, were rejected.

South Carolina had the largest percentage of rejections. It sent 59,647 men to induction stations which rejected 21,033, or 35.3 per cent. The rejection of whites was 31.6 per cent, and of negroes 41 per cent. Michigan followed closely with rejections of 34.4 per cent.

The best record was made by Wyoming, which sent 7,892 men to induction stations and had only 1,031, or 13.1 per cent, turned back. A perfect record on a racial class was reported for North Dakota, which sent ten negroes to induction stations and had ten accepted.

Trailing Wyoming for low percentages of rejections were Utah, Kansas, Washington, Iowa, South Dakota, Nevada, and Connecticut.—San Francisco *News*, August 26.

Rejects in the Draft

United States Turns Out Too Many Morons, Says General Hershey; Social Changes Are Urged

Fifty Per cent of Men Over Thirty Can't Pass Army Tests; One-Third of These Are Mental Cases

A plea to the nation to remake its social and educational system after the war so that "so many middle-class morons and physically unfit fathers won't be turned out," was made yesterday morning during a press conference by National Director of Selective Service Major General Lewis B. Hershey.

In referring to the great problem faced by draft officials in handling the 3,000,000 4-F's and the 50 per cent rejects on draft candidates over 30, General Hershey said:

"After the war let's readjust our lives so that men can pass moderate physical examinations when they're over 30, and let's not have a third of those examined rejected for mental reasons.

"There are too many middle-class morons in the country, people with mental diseases who can't pass Army tests. I hope after the war we have time to grow up mentally."

The National Director of Selective Service admitted that local draft boards faced " a nasty job ahead" in drafting fathers, which he intimated would begin some time in October, or soon thereafter, depending on the fluctuating supply of 1-A's and adolescents graduating into the 18-year-old group.

"We are going to be realistic," he told reporters at the San Francisco Press Club, where the conference was held. "We are not going to keep men out of the ranks to do work that women can do."

At the same time, he said, the nation must protect its airplane factories and shipyards—and other industries that "supply the war fronts."

He gave figures for single men deferred on farms and industries—700,000 on the farms and 1,000,000 in war industries. An additional 300,000 in the nation are being allowed to remain in school or training to become doctors, chemists, and technicians for use in peacetime years.

"We have quite a backlog of fathers—about 17,000,000 of them," said General Hershey. "We are down to the bottom of the barrel on 1-A's and all we have left on the shelves are the cardiacs, psycopaths, and the military forces are getting a little particular."

He described the married group as a "pressure group," with millions of wives, children, and mothers-in-law rooting to keep them from being drafted.

Their average age, he said is 31 years, and of this group there will be from 40 to 50 per cent rejections for physical disabilities. After other deferments are made, he predicted the draft boards might not be able to obtain more than 2,000,000 "out of the entire bunch." . . .—San Francisco *Chronicle*, August 8.

Aid Stations for Sicily Wounded Always on the Go

Somewhere in Sicily (By Wireless).—Probably it isn't clear to you just how the Army's setup for the care of the sick and wounded works on a battlefront. So I'll try to picture it for you.

Let's take the medical structure for a whole division, such as the 45th, which I have been with recently. A division runs roughly 15,000 men, and almost 1,000 of that number are medical men.

To begin right at the front, three enlisted medical-aid men go along with every company. They give what first aid they can on the battlefield. Then litter-bearers carry the wounded back to a battalion aid station.

Sometimes a wounded man is taken back right away. Other times he may be pinned down by fire so that the aid men can't get to him, and he will have to lie out there for hours before help comes. Right there in the beginning is the biggest obstacle, and the weakest feature of the Army's medical setup.

Once a soldier is removed from the battlefield his treatment is superb. The battalion aid station is his first of many stops as he is worked to the rear and finally to a hospital. An aid station is merely where the battalion surgeon and his assistant happen to be. It isn't a tent or anything like that—it's just the surgeon's medical chest and a few stretchers under a tree. Each station is staffed by two doctors and thirty-six enlisted men. They are very frequently under fire.

At an aid station a wounded man gets what is immediately necessary, depending on the severity of his wounds. The idea all along is to do as little actual surgical work as possible, but at each stop merely to keep a man in good enough condition to stand the trip on back to the hospital, where they have full facilities for any kind of work. Hence if a soldier's stomach is ripped open they do an emergency operation right at the front, but leave further operating to be done at a hospital. If his leg is shattered by shrapnel they bind it up in a metal rack, but the operating and setting isn't done till he gets back to the hospital. They use morphine and blood plasma copiously at the forward stations to keep sinking men going.

* * *

From the battalion aid station the wounded are taken by ambulance, jeep, truck, or any other means, back to a collecting station. This is a few tents run by five doctors and 100 enlisted men, anywhere from a quarter of a mile to several miles behind the lines. There is one collecting station for each regiment, making three to a division.

Here they have facilities for doing things the aid station can't do. If the need is urgent they re-dress the wounds and give the men more morphine, and they perform quite a lot of operations. Then the men are sent by ambulance on back to a clearing station.

The 45th Division has two clearing stations. Only one works at a time. While one works the other takes a few hours' rest, then leapfrogs ahead of the other one, sets up its tents and begins taking the patients. In emergencies, both clearing stations work at once, temporarily abandoning their rest-and-leapfrog routine.

All these various crews—the company aid men, the battalion aid station, the collecting station, and the clearing station—are all part of the division. They move with it, fight when it does, and rest when it does.

* * *

Then back of the clearing stations the hospitals begin. The first hospitals are usually forty miles or more back of the fighting. The hospitals are separate things. They belong to no division, but take patients from everywhere.

They get bigger as you go back, and in the case of Sicily patients are evacuated from the hospitals right onto hospital ships and taken back to still bigger hospitals in Africa.

The main underlying motive of all front-line stations is to get patients evacuated quickly and keep the decks clear so they will always have room for any sudden catastrophic run of battle casualties.

A clearing station such as the one I was in is really a small hospital. It consists of five doctors, one dentist, one chaplain, and sixty enlisted men. It is contained in six big tents and a few little ones for the fluoroscope room, the office, and so forth. Everybody sleeps outdoors on the ground, including the commanding officer. The mess is outdoors under a tree.

The station can knock down, move, and set up again in an incredibly short time. They are as proficient as a circus. Once, during a rapid advance, my station moved three times in one day.—Ernie Pyle, in San Francisco *News*, August 16.

Streams of Wounded Get Swift, Efficient Treatment

Somewhere in Sicily (By Wireless).—Army ambulances carry four stretchers each, or nine sitting wounded. When they reach a clearing station they back up to the surgical tent and unload.

The men lie there on their stretchers on the floor of the tent while the aid men look at their tags to see how severe the wounds are, in order to handle the worst ones first. Those who don't need further attention are carried right on through to the ward tents to wait for the next ambulance back to a hospital.

Those who have graver wounds are carried into the operating room. Two big Army trunks sit up-ended there on the dirt floor. The trunks contain all kinds of surgical supplies in drawers. On top of each trunk is fastened a steel rod which curves up at each end. The wounded man is carried in his litter and set on these two trunks. The curved rod keeps him from sliding off. His litter thus forms his operating table.

A portable surgical lamp stands in a tripod over the wounded man. A little motor and generator outside the tent furnish power, but usually they just use flashlights. One or two surgeons in coveralls or ordinary uniform bend over the man and remove his dressings. Medical-aid men crowd around behind them, handing them compresses or bandages with steel forceps from a sterile cabinet. Other aid men give the patient another shot of morphine or inject blood plasma or give him a drink of water from a tin cup through a rubber tube they put in his mouth.

Incidentally, one of the duties of the surgical ward boys is to keep the sweat wiped off the surgeon's face so it won't drop down onto the wound.

* * *

Just outside the surgical tent is a small trench filled with bloody shirt sleeves and pants legs the surgeons have snipped off wounded men to get at the wounds more quickly. The surgeons re-dress the wounds, and sprinkle on sulfanilamide as though it were ant powder. Sometimes they poke for buried shrapnel, or recompress broken arteries to stop the flow of blood, or inject plasma if the patient is turning pale.

They don't give general anesthetics here. Occasionally they give a local, but usually the wounded man is so doped up with morphine by the time he reaches here he doesn't feel much pain. The surgeons believe in using lots of morphine. It spares a man so much pain and consequently relieves the general shock to his system.

On my third day at the clearing station, when I was beginning to feel better, I spent most of my time around the operating table. As they would undress each new wound, I held firmly to a lamp bracket above my head, for I was still weak and I didn't want to disgrace myself by suddenly keeling over at the sight of a bad wound.

Many of the wounds were hard to look at, and yet Lieutenant Michael de Giorgio said he had never seen a human body as badly smashed up here as he had in traffic accidents back in New York, where he practiced. . . .

But most of the wounded say nothing at all when brought in—either because they see no acquaintance to talk to, or because they're too weak from their wounds or too dopey from morphine. Of the hundreds that passed through while I was there I never heard but one man groaning with pain.

Another thing that struck me as the wounded came through in a ceaseless stream on their stretchers was how dirt and exhaustion reduce human faces to such a common denominator. It got so everybody they carried in looked alike. The only break in the procession of tired and dirty men who all looked exactly alike would be when an extreme blond would be carried in. His light hair would seem like a flower in a row of weeds.—Ernie Pyle, in San Francisco *News*, August 17.

Armed Services Need Six Thousand More Doctors

Chicago, Aug. 5 (UP).—The armed forces must have six thousand additional physicians by January 1.

To achieve this goal, generals in command of the various service commands have been authorized to induct physicians between the ages of 38 and 45 who have been declared available by the directing board of the procurement and assignment service for physicians, dentists, and veterinarians, *The Journal of the American Medical Association* said.

If not enough doctors respond to the call, *The Journal* predicted that the needs of the armed forces will be met by specific regulations of the Selective Service administration for the enactment of special legislation.—Fresno *Bee*, August 5.

(COPY)

The Bulletin of the Los Angeles County Medical Association

Open Meeting Procurement and Assignment Service for Physicians and Dentists

Many important questions will be discussed at the meeting on August 23, 1943, including announcements of new policies as to recruiting of all available physicians and dentists under 45 years of age.

All physicians, dentists, and hospital executives are urged to be present.

* * *

Edward M. Pallette, M. D.
Southern California State Chairman for Physicians
Procurement and Assignment Service
1930 Wilshire Boulevard
Los Angeles, California

August 7, 1943.

Send immediately to state directors of Selective Service names and addresses of physicians under 45 years of age who have been declared available by Procurement and Assignment Service and who have refused to apply for commissions. Copies of these names and addresses should be sent to Central Office. National Headquarters Selective Service has authorized state directors to appeal such cases whose local boards now have them in deferred classification. Letter follows.

M. E. Lapham, M. D.,
Executive Officer, Procurement and
Assignment Service for Physicians,
Dentists, and Veterinarians
Washington, D. C.

Plasma Here Is Ample for Civilian Use

The civilian population of the West Coast can now be assured of an adequate supply of blood plasma in case of disaster, states Dr. Charles R. Lowe, assistant surgeon, reserve, of the U. S. Public Health Service. Doctor Lowe has just finished a tour of the Coast to inspect blood bank facilities.

Doctor Lowe explained that, although the plasma quotas for military personnel are far from complete, civilian needs have been studied ever since Pearl Harbor and a plan drafted whereby every community has a good supply of plasma.

The West Coast "target areas" now have 34,500 units of plasma available for civilian use, Doctor Lowe revealed. It is so stored that any place within the area can be reached in 30 minutes with added supplies if district stocks should be exhausted.

Both dried and frozen plasma are being stored for emergencies on the Coast. Twelve hospitals have 500 units each and three hospitals in large cities, 1,000 units each, according to a recent survey.

The Army and the Red Cross have supplied the dried plasma and it is figured that every small town has an available supply of from 20 to 25 units at all times.

"Blood plasma is the greatest single factor saving the lives of wounded servicemen today," Doctor Lowe said. "The Red Cross has done a magnificent job with their blood donor program, and the Public Health Service and Civilian Defense are grateful for their unequaled contribution."

Doctor Lowe added that medical science is continually finding increased use for blood plasma, and the amounts needed will continue to increase even when this war is ended.—San Francisco *Chronicle*, August 8.

Stretcher Teams

Office of Civilian Defense Medical Division Defines Duties of Stretcher Teams in Emergency Medical Service

The Medical Division of the Office of Civilian Defense in an Operations Letter issued June 30 defines the duties of Stretcher Teams of the Emergency Medical Service as these duties have been modified by the recent development of the specialized Rescue Service.

Rescue Squads are now to assume the duties formerly assigned to the Stretcher Teams at major incidents with many trapped casualties. In addition to the technical work of rescue, this includes emergency care and transport of casualties from the scene of an incident to an ambulance or to a point where medical service is available. Stretcher Teams remain, however, an essential part of the Emergency Medical Service, the Medical Division points out. The functions of the teams as outlined in the new statement are as follows:

1. Assisting medical personnel at Casualty Stations in handling and nonprofessional care of minor casualties.

2. Unloading ambulances and assisting in reception of casualties at hospitals.

3. Performing rescue work at minor incidents not requiring specialized rescue squads.

4. Assisting Rescue Squads at major incidents at which many casualties are trapped.

A Stretcher Team is composed of a leader and four other persons, preferably men and older boys from the neighborhood of the facility to which they are attached. The Medical Division urges that members of a hospital staff who have maintenance functions should not be selected for duty on a Stretcher Team.

A group of teams attached to any facility is under a group leader, who is responsible for the organization and training of members of his team. . . .

Office of Civilian Defense Urges Recognition of Health Officials in Civilian Protection Organization

In order that health and sanitation may be maintained during and after an air raid or other wartime disaster, health officers, with their deputies, division chiefs and sanitary inspectors, should be members of the United States Citizens Defense Corps, the Office of Civilian Defense advises in Operations Letter No. 131, entitled "The Health Department in Civilian Protection."

Commanders of the United States Citizens Defense Corps are urged to appoint health officers to their staffs.

Health officers should develop plans for prompt action in emergencies to assure: (1) maintenance of safe water, food, and milk supplies; (2) sanitary disposal of sewage and putrescible wastes; (3) sanitation at mass feeding centers, rest centers, casualty stations, billets, and other temporary facilities for war emergencies; and (4) control of communicable disease, the Operations Letter points out. Planning should include the mechanism for mobilizing essential personnel during and following an emergency, it is suggested. Another important duty will be to make arrangements for immediate instruction of the public in emergency sanitary measures. . . .

Office of Civilian Defense Announces Organization Plan for Rescue Service

Plans for the organization of the Rescue Service, which is responsible for the recovery of persons trapped under the structural débris of demolished buildings in the event of enemy action, were issued June 24, by James M. Landis, Director of the United States Office of Civilian Defense, in Operations Letter No. 133. . . .

Although the Rescue Service is being organized nationally under the direction of the Medical Division of the Office of Civilian Defense, State and local Rescue Services will be separate from the Emergency Medical Service. Local Chiefs of Rescue and Emergency Medical Services will work in close coördination in the Control Center. When reports are received of persons trapped by the débris of buildings demolished by an air raid or other enemy action, an Express Party is dispatched, which consists of one Rescue Squad, one Mobile Medical Team, and one ambulance and one sitting-case car.

Rescue workers, who should be recruited from workers in the building and demolition trades, mine workers, mechanics, petroleum industry workers and tunnel workers in the heavy construction industry are to be organized in squads of ten. The squads should be based in depots, each of which should have a complement of three squads rotating on periods of first call.

The Office of Civilian Defense recommends an average of one depot for each 50,000 population in target areas. The number in each locality, however, will depend on the types of buildings and on the area over which the community is spread, as well as on the number of residents. In sections in which houses are largely of frame construction or of the one-story type, fewer Rescue Squads will be needed because trapped persons will be fewer and their extrication less difficult. The national program contemplates an establishment of about 1,000 depots and a full rescue personnel of 30,000 organized into 3,000 squads. . . .

Penicillin Production

War Production Board Acts to Boost Wonder Drug Output

Washington, Aug. 29.—Nine companies have received the blessing of the War Production Board to build new facilities to boost production of penicillin, the scarce but vitally needed wonder drug, it was learned today.

Just a little more than a year ago penicillin was only a laboratory curiosity, but now scientists hail it as many times more potent than the famed sulfas, and producers are besieged with demands for supplies.

Four of these expanding firms and three others already had been producing the drug, but five are entering as newcomers in this fast developing field. Total cost of the expansion for the nine firms will exceed $3,000,000, WPB records show.

Although there is virtually no yardstick for determining rate of output, due to the drug's newness, WPB officials estimated the new producers would have some stocks of penicillin available within three to six months.

Even if production is tripled, the demand will far exceed the supply at least for the duration, the WPB believes, and only a very small amount will be available for civilian use.

Although the Army only gets 50 per cent, as announced last week by Surgeon-General Norman T. Kirk, other units of the armed forces, as well as maritime workers, receive their share, and large supplies are needed for continued research and tests.

All control of the drug for civilian use is vested in one man, Dr. Chester S. Keefer, director of the Evans Memorial Hospital in Boston and chairman of the national research council's committee on chemotherapeutics.

Call Doctor Keefer

By agreement of the various agencies working to develop penicillin, every gram allocated to civilians goes to Doctor Keefer and he passes it along to hospitals for clinical tests or to specific doctors.

Officials here emphasized that when patients in extreme cases need it their doctors should get in contact with Doctor Keefer and he would provide some—if conditions merit and he has any available.

Penicillin is rated by scientists as the most potent weapon ever found against many diseases, among them pneumonia, gonorrhea, and blood poisoning. It is particularly effective in combating staphylococci, which are bacteria wound infectors or pus formers.

Yellow Magic

The major drawback has been that penicillin is incredibly difficult to produce. In its finished form it is a yellow-brown powdery stuff, not at all impressive looking. However, to obtain this, chemists must grow mold in flasks, extract the fluid in the growth and from it obtain the "yellow magic."

But often the molds refuse to secrete the needed juice. Even when they do, too, the yield is pitifully small.

The WPB records showed the nine companies which have had applications approved for expansion include the Cutter Laboratories, Berkeley, California.—San Francisco *Chronicle,* August 30.

Medical Group Calls Penicillin Potent Weapon

Chicago, Aug. 25 (AP).—The National Research Council, in its first clinical report on penicillin, today praised the new bacteria-killing agent, calling it a "most potent weapon."

The Council's committee on chemotherapeutic and other agents, of the division of medical sciences, outlined in the *Journal of the American Medical Association* the results of 500 cases of infection treated with penicillin.

"Penicillin has been found to be most effective in the treatment of staphylococcic, gonococcic, pneumococcic and hemolytic (blood destroying) streptococcus infections," the report said.

The committee related that out of 129 cases of gonococcic infection—all of which failed to respond to the sulfa drugs—125 were free from symptoms and no bacteria could be found within nine to forty-eight hours after treatment with penicillin.

"Here, then, is a most potent weapon in the treatment of sulfonamide-resistant gonorrhea, and it is not too much to predict that penicillin will prove to be one of the most effective agents in the treatment of a disease that causes great ineffectiveness in the armed forces and in the civilian population.—Los Angeles *Times,* August 26.

California Medical Association Council Action re Maternity-Pediatric Program

Federal Children's Bureau Maternity-Pediatric Plan:

General discussion concerning the federal Children's Bureau maternity and pediatric plan took place.

It was agreed that there was no reason to change the outline of procedure as given in the letter dated July 1, 1943, which was sent to the component county societies by Council Chairman Gilman, and printed in the July issue of California and Western Medicine, as Item XI, on page 83.

Attention was called to the statement received from the California State Board of Health that, when a physician contracted to accept obstetric or pediatric work under the federal Children's Bureau plan, the physician, under the regulations put forth by the Children's Bureau of the United States Department of Labor, is not permitted to accept the payment from the California State Board of Public Health—acting for the federal Children's Bureau—and also accept an additional payment from the patient *for the same service*. However, for services to mother or child that are not included in the authorized schedules of the Children's Bureau, payments therefor may be made by the patient.

Maternity-Pediatric Plan of Federal Children's Bureau

(Additional Items—Continued from Pages 79-88, July California and Western Medicine)

California and Western Medicine for July on pp. 79-88, submitted eighteen items related to what has become known as the federal Children's Bureau plan for the obstetric and pediatric care of wives and infants of enlisted men. Owing to change of California and Western Medicine printer from Los Angeles to San Francisco with loss of some copy, delayed mails, the publication being in press, etc., it was not possible to find space in the August number for some items that contained other information. Editorial comment appeared in the August issue. To what has already been printed, the following items may be added.

* * *

ITEM XIX

(copy)

Washington, D. C., June 16, 1943.

Dear Doctor Kress:

In the mimeographed copies of your letter of May 24 to Doctor Tollefson and your June 1st letter to Doctor Olin West, a statement attributed to me relative to the 1938-1939 county medical society fee schedule study of the American Medical Association has been slightly misquoted. I stated that the Children's Bureau had reviewed the material prepared by the American Medical Association and observed that the average fee submitted by 360 county medical societies for normal deliveries was $35. Actually, this report shows that the mean average of the minimum fees submitted was $28.58 and the mean average of the maximum fees submitted was $42.71. The average fee would be between these two figures.

It was a pleasure to have the opportunity of meeting with the northern and southern "Liaison Committees with the California State Board of Public Health" and to observe the close and harmonious working relationships between the public health agency and the practicing physicians. California is indeed fortunate in having Doctor Halverson for its State Health Officer and Doctor Bierman for its Director of the Bureau of Maternal and Child Health.

Sincerely yours,

Edwin F. Daily, M. D.,
Director, Division of Health Services.

(copy)

July 10, 1943.

George H. Kress, M. D.,
Secretary-Editor,
San Francisco, Calif.

Dear Doctor Kress:

Thank you for sending me the section of the June issue of the California and Western Medicine relating to maternity and infant care for wives and infants of enlisted men in the armed forces. I feel confident that the physicians in California will give Doctor Halverson wholehearted support and coöperation in making these services available to the families of enlisted men under the provisions of the plan prepared by the California State Health Department and approved by the Children's Bureau on June 30, 1943.

In reply to your inquiry about the study of fee schedules, may I refer you to my letter to you dated June 16, 1943, copy of which is enclosed. This data was compiled by the Bureau of Medical Economics of the American Medical Association in 1938 or 1939. A photostatic copy of this unpublished study was made available to the Children's Bureau by the U. S. Public Health Service.

Sincerely yours,

Edwin F. Daily, M. D.,
Director, Division of Health Services.

* * *

(copy)

August 21, 1943.

Dear Doctor Kress:

A copy of the July issue of California and Western Medicine has been sent to this office, I presume at your request. Thank you for this courtesy.

In reviewing the eighteen items of correspondence on pages 79 to 87 relating to the emergency maternity and infant care program, you have omitted my letter dated June 16, 1943, to you and my reply of July 10, 1943, to your letter of July 8, 1943, although both of these letters were received by you before some of the other correspondence reprinted. Since the subject matter of these two letters is referred to repeatedly in other correspondence printed, it seems only fair that your readers be given an opportunity to review the complete correspondence.

In the last sentence of Doctor Gilman's letter of July 1 to members of the California Medical Society it is stated, concerning the emergency maternity and infant care program, "Therefore, members of the Medical Association as individual physicians are free to accept payments from either the California State Board of Public Health, or from a patient, or from both." This statement is in error. The plan of the California State Department of Public Health, as approved by the Chief of the United States Children's Bureau, provides that the attending physician will agree in writing not to accept payment from the patient or her family for services authorized by the State Department of Public Health under the emergency maternity and infant care plan.

I will appreciate your courtesy in publishing this letter and the two letters mentioned above.

Sincerely yours,

Edwin F. Daily, M. D.,
Director, Division of Health Services.

* * *

ITEM XX

Obstetric and Pediatric Care for Wives and Children of Enlisted Men

[Letter sent by Dr. George H. Kress, Secretary-Editor, California Medical Association, August 6, 1943:]

Dear Doctor West:

We continue to be much interested in the Federal Children's Bureau Plan.

We have noted the following articles in *The Journal*:

Maternity Care for Wives of Enlisted Men, *The Journal,* July 17, p. 816.

Daily, E. F.: Medical and Hospital Maternity and Infant Care, *ibid.,* July 31, p. 945.

I am writing to ask if any other articles appeared in *The Journal* on the subject, and if so will you kindly send me the references?

Thanking you for your prompt attention to this,

Cordially yours,
George H. Kress, M. D., San Francisco.

* * *

[Reply of Dr. Olin West, Secretary, American Medical Association, sent August 10:]

Dear Doctor Kress:

Your letter of August 6 was received on August 9, since which time I have had prepared a list of references to items pertaining to obstetric and pediatric care for the wives and children of service men that have appeared in *The Journal of the American Medical Association.*

I presume you know that the program of the Children's Bureau for providing obstetric service was initiated in the State of Washington in 1941 and was extended to other states, beginning in August, 1942.

In the Federal Legislative Bulletin No. 19 of our Bureau of Legal Medicine and Legislation, dated September 1, 1942, there was a three-page discussion of legislation introduced at the request of the President of the United States proposing an additional appropriation for the Children's Bureau. Part of this appropriation was to be used to provide maternity services for the wives of service men. This bulletin was sent to the officers of all state medical associations.

On page 47 of *The Journal* for September 5, 1942, there appeared an editorial comment on the two bills that had been introduced at the request of the President. It was pointed out in the editorial comment that part of the appropriation provided for in the bills was to be used for maternity care for the wives of service men. In the same issue of *The Journal,* on page 58, there was a brief reference to the introduction of these two bills, neither of which was enacted.

In *The Journal* for November 14, 1942, on page 846 there was an item under the title "Medical Care for Wives and Infants of Men in Military Service" in which reference was made to the program of the Children's Bureau and to the fact that funds had been set aside by the Bureau from its appropriation for the fiscal year 1943 in the amount of $198,000.

In *The Journal* for November 21, 1942, on page 974 there was a news item descriptive of the plan being put into operation in the State of Missouri for providing medical and hospital obstetric and pediatric care for the families of men serving in the armed forces.

On page 603 of *The Journal* for February 20, 1943, reference was made to a supplemental estimate that had been submitted to the Seventy-Seventh Congress by the President asking for an appropriation of $1,200,000 to be used by the Children's Bureau in making grants to states to provide medical, nursing and hospital maternity and infant care for wives and babies of enlisted men of certain grades serving in the armed forces. In the Federal Legislative Bulletin No. 25, dated March 1, 1943, reference was made to this supplemental estimate that had been submitted to Congress and to the fact that the House Committee on Appropriations had refused to include the estimate in the deficiency appropriation bill, H. R. 1975.

On page 872 of *The Journal* for March 13, 1943, reference was made to a bill introduced by Representative Keefe, H. R. 2041, proposing to authorize an appropriation of $6,000,000 for each fiscal year during the war and for six months thereafter to provide obstetric and pediatric care for the wives and infants of service men. This bill, as I am informed, is still in the hands of the House Committee on Education and Labor.

In the Federal Legislative Bulletin No. 25, dated April 5, 1943, reference was made to the fact that when the deficiency appropriation bill, H. R. 1975, came before the Senate for consideration there was included in the bill the appropriation requested by the President, and that the House thereafter agreed to this appropriation and the President signed the bill. In this same issue of the Bulletin reference was made to the bill introduced by Representative Keefe.

On page 1231 of *The Journal* for April 10, 1943, there was an item under the heading "Medical Care for the Wives and Children of Enlisted Men" which referred to the appropriation of $1,200,000 that had been made available for obstetric and pediatric services, to the regulations that had been promulgated by the Department of Labor under date of March 26 for the allotment of this money and to the nature of the testimony given by the Chief of the Children's Bureau before a subcommittee of the House Committee on Appropriations in support of the request for the appropriation.

On page 1379 of *The Journal* for April 24, 1943, there appeared in the Report of the Board of Trustees a reference to the federal program here under discussion.

On page 382 of *The Journal* for June 5, 1943, there was an item under the title "Maternity Care for Wives of Certain Grades of Enlisted Men," summarizing the extent to which the plan had been put into operation.

There appeared in *The Journal* for June 26, 1943, on page 628 a reference to H. R. 2935, the Labor Department-Federal Security Agency appropriation bill for the fiscal year ending June 30, 1944, which contained at that time provision for the appropriation of $4,000,000 for the use of the Children's Bureau in carrying out the program under discussion. This sum was increased before the appropriation bill was enacted to $4,400,000.

On page 621 of the same issue of *The Journal* reference was made to the action taken by the House of Delegates of the American Medical Association in approving generally the action of the Federal Government in making funds available for maternity and infant care for the wives and infants of enlisted men, but recommending that allotments be paid directly to the wives.

In the Federal Legislative Bulletin No. 28, under date of July 15, 1943, reference was made to the enactment of the Labor Department-Federal Security Agency appropriation bill authorizing the appropriation of $4,400,000 for grants to states to provide obstetric and pediatric care.

On page 816 of *The Journal* for July 17, 1943, there appeared a statement which was in the nature of a summary of the report issued by the Secretary of Labor on the progress made in the several states in carrying out the program of the Children's Bureau.

In *The Journal* for July 31, 1943, beginning on page 945, there appeared a special article by Dr. Edwin F. Daily, director of the Division of Health Services of the Children's Bureau.

There have been other references in special legislative bulletins sent to all state medical associations by our Bureau of Legal Medicine and Legislation pertaining to the proviso included in the appropriations bill, H. R. 2935, which places certain restrictions on the Children's Bureau.

There seems to have developed an impression on the part of many that the plans of the Children's Bureau for providing obstetric and pediatric services for the wives and infants of enlisted men were not initiated until March 18, 1943, on which date the President signed the deficiency appropriation bill in which was included provision for the appropriation of $1,200,000 to finance the program of the Children's Bureau for the remainder of the fiscal year. The fact is that the program of the Children's Bureau was initiated in 1941 after the Department of Health of the State of Washington had petitioned the Children's Bureau for financial assistance to help in providing obstetric and pediatric service for the wives and children of enlisted men stationed at Fort Lewis. That was the first project started, and no other similar project was put into operation until August, 1942. In the time between August, 1942, and February, 1943, programs quite similar to the one initiated in the State of Washington became effective in twenty-seven states, and the Children's Bureau made available the sum of $390,177, to be used in financing the programs in those states. These funds were set aside by the Bureau from the regular appropriation authorized for maternal and child health services under Part 1 of Title V of the Social Security Act. Our information is to the effect that other states than the twenty-seven referred to made application for funds to be similarly used, which could not be granted because the Bureau had no additional funds available.

In view of the fact that at least twenty-seven states collaborated in the program of the Children's Bureau over a considerable period of time, it is a little surprising that no state medical association found the program so objectionable as to induce the filing of any complaints with the American Medical Association. I have heard that the program was approved in some states, though I have no official advices to that effect. However, articles appeared in some state medical journals that were entirely favorable to the Bureau program. In the *Journal of the Medical Society of New Jersey* for November, 1942, there appeared a two-page statement in which it was stated that the medical society of New Jersey had agreed to participate in the program and the reasons for that decision were given. A somewhat similar statement appeared in the *Journal of the Missouri State Medical Association* for November, 1942.

I presume that by this time you have received a release from our Bureau of Legal Medicine and Legislation pertaining to the opinion of the Attorney-General of the United States with respect to the effect of the provisos that were included in the appropriation bill for the Department of Labor, of which the Children's Bureau is a part.

It will no doubt interest you to know that I had a visit a few days ago from the health officer of one of our larger Middle West states, who stated that applications for obstetric and pediatric service for the wives and children of soldiers were coming into his office at the rate of one thousand a month and that the tentative estimate indicated that the cost of such service in that one state under the Children's Bureau program probably would amount to $1,250,000 a year. In that particular state, I understand, the fee for obstetric service including antepartum and postpartum care will be fixed at $45. Our visitor made a very interesting point when he stated that in many if not in most instances the wives of soldiers demand that they have the services of the best qualified obstetricians, who are already overwhelmed with work, and he expressed a fear that the obstetricians would be put in a bad light if they refused to serve the wives of soldiers under the Children's Bureau-State Health Department program even though their own private practice demanded every minute of their time.

If this service is to cost a million and a quarter in one state, the appropriation of $4,400,000 will be exhausted very rapidly.

With most cordial good wishes, I am

Very sincerely yours,
Olin West.

[Letter from Dr. George H. Kress, Secretary-Editor, California Medical Association, sent August 17, 1943:]

Dear Doctor West:

Many thanks for your courtesy in sending to me your letter of August 10 with its information concerning references in *The Journal* on maternity-pediatric care.

The letter was received too late to be of use in my August editorial for California and Western Medicine.

I am very glad to have this information for our files.

Cordially yours,
George H. Kress, M. D.,
Secretary-Editor.

* * *

ITEM XXI

Two Informative Letters—Re: Federal Children's Bureau Plan

(copy)

Station Hospital
Reading Army Air Field
Reading, Pa.,
18 August, 1943.

Dr. Wilton L. Halverson,
Department of Public Health,
760 Market Street,
San Francisco, California.

Dear Hal:

I was interested in the discussion of the problem of providing obstetrical care for wives of soldiers in California and Western Medicine.

If Doctor Daily's only desire is to carry out the specifications of Congress in administering these funds for the welfare of the soldiers' families, the solution should be very simple. The requirements mentioned in his letter on page 82 can be easily fulfilled and I am confident receive the coöperation of the California Medical Association in carrying out this program.

Knowing how much financial assistance she could depend upon, the soldier's wife could approach the doctor of her choice and make arrangements for care in the usual way. At the usual time the doctor would present his bill. The patient would forward it to you. You would make out a check to the doctor and return it to her. She would make out an additional check if necessary, and remembering that some soldiers are quite wealthy, and forward it to the doctor. Nurses and hospital bills could be handled similarly.

This method would seem to avoid all the objections voiced by either side in the discussion. It would maintain the highest standards of medical practice. It would assure the patient's confidence in her doctor. In assuring the Bureau that the funds were being expended for medical, hospital and nursing care, it would satisfy all the Congressional specifications mentioned by Doctor Daily. By giving you information on the total charges it would prevent additional charges, except where justified by the patient's financial standing from sources outside the Army. I am sure the California Medical Association would wholeheartedly coöperate in preventing any excessive charges. It would give the profession as a whole the feeling that governmental funds are going to be used for the welfare of the patient and not as a political club. It would assist in the future coöperation of the medical profession and the Government in solving the financial problems involved in providing modern medical care for all the people, which apparently is not being aided by the present deadlock.

Knowing your sincerity and understanding of the many factors involved, I am sure you will continue to work for a satisfactory solution of this problem which is so important to our soldiers.

With very best wishes, I am

Sincerely yours,
(Signed) Lewis T. Bullock.

* * *

(copy)

State of California
Department of Public Health
Wilton L. Halverson, M. D.
Director of Public Health

Lewis T. Bullock, Captain, M. C.,
Station Hospital,
Reading Army Air Field,
Reading, Pa.

Dear Captain Bullock:

Doctor Raffety has referred to me your letter of August 18 and we are very grateful to you for your interest in the problems of providing satisfactory maternity and infant care for the dependents of enlisted men here in California, and for your constructive suggestions.

It has been apparent throughout our negotiations that there has been no difference of opinion on the desirability of making it possible for these people to obtain good care. The difficulties have centered about the methods to be employed. We in the State Health Department have been given very little to say in this regard, as the federal plan outlined by the U. S. Children's Bureau is quite inflexible. We have been able, however, to gain a few concessions from the Children's Bureau because of conditions prevailing in this State, particularly with regard to the purchase of hospital care, and we are still hopeful that some other changes may be made possible.

We are particularly glad to have your letter just now, as it contains suggestions which may prove helpful to us in solving some of our current problems.

It is our earnest desire to work this thing out with the medical profession and hospitals in a manner that will assure the best possible care for the soldiers' families and not create injustices for any concerned.

Very sincerely,
Jessie M. Bierman, M. D.,
Chief, Bureau of Maternal and Child Health.

ITEM XXII

Federal Children's Bureau Versus Ohio State Medical Association

Ending weeks of Federal-state difference, State Health Director R. H. Markwith announced Wednesday that Ohio would accept, with only minor changes, the same Federal Children's Bureau childbirth program for the wives of men in the armed forces that has been accepted by thirty-nine other states.

"Our hands are tied by the congressional act establishing the program," he said. "There's nothing else we can do and still participate in the Federal aid plan."

The director delayed acceptance of the plan until the Ohio State Medical Association and other agencies had attempted to draft a substitute, workable program which would overcome the objection of the Association that the bureau plan threatened to "socialize" the practice of medicine.

Never Rejected

Contrary to reports, Doctor Markwith said the plan never had been finally rejected.

"It was never turned down flat," he stated. "We delayed acceptance to give the Association time to work out an acceptable plan of its own. Its attempts have been stymied, and we now are forced to accept the bureaucratic plan if the wives of our service men are to be afforded any protection at all."

Details of the plan which will be placed in effect in Ohio will be worked out in a series of conferences beginning Thursday, when Dr. Edwin Daily of the Children's Bureau will come from Washington to confer with Markwith.

Success Seen

"Without doubt, a plan will be worked out which will meet with the requirements of the Children's Bureau and also one in which the Ohio State Medical Association will be willing to participate, even if a bit unwillingly," said the health director.

"Governor Bricker, the Association and I have always been in sympathy with the general program of Federal aid, but we have not always seen eye to eye with the Children's Bureau in the way it should be administered.

"We submitted a compromise proposal, based on the congressional act, to the Bureau on May 6, and it was returned to us on May 17 with suggested corrections. That probably will be the basis for the finally accepted plan."

Has $200 Ceiling

The Federal plan calls for a maximum doctor's fee of $35, and has a ceiling of $200 for all prenatal and postnatal expenses. It would allow a maximum of $60 for hospital care, $25 for surgery, $70 for nurse's care if needed, and $10 for ambulance service. However, the national average expenditure under the program is only about $30.

The Medical Association objected to the plan on the ground it would socialize medicine, inasmuch as a doctor would be paid direct by the Federal government, and was limited to the fee he could charge even though relatives or other agencies were willing to make up any deficit not covered by the $35 maximum.

Direct Grants Favored

The Association favored among other things direct grants to the expectant mothers, who then could use the funds as they saw fit. Other details of their plan Doctor Markwith refused to reveal, but it was learned from other sources that it called for participation by the army and navy relief societies.

This was "stymied," however, by Washington pressure, it was charged, and the service relief organizations then took the position that their funds should not be expended when congress had appropriated $4,000,000 to finance the childbirth program.

Backers of the Association plan complained bitterly that the army-navy relief societies would have been willing to live up to their boast that "the army (or navy) takes care of its own" until bureaucratic pressure was brought to bear in Washington. They pointed out that the army-navy relief funds already total more than $9,000,000, with additional millions coming in from movie rights.

Another Suggestion

Still another suggestion—it was no more than that—was one advanced by Markwith. It was that the regular soldier dependency allowances—$12 a month for the first child and $10 for each subsequent child—be started at conception instead of at birth. Thus by the time a child was born a fund of $90 or $108 would have been established.

"The machinery for such a program already has been established," Doctor Markwith pointed out, "but no one saw fit to take up that plan. Perhaps it's too simple and workable for bureaucratic minds."

No Secret

Despite his ultimate acceptance of the Federal plan, Markwith made no secret of his bitter opposition.

"Regardless of what they say, it is not open to the wives of all enlisted servicemen," he asserted. "It is open only to those who can find a $35 doctor, and who are willing to have their babies in a ward rather than in a private or semi-private room.

"We're not satisfied, but we're trying to get the best possible assistance for the wives of our men in the services. We won't certainly get all we want, or all we believe we should have, but we'll do the best we can."—Robert Vincent, I. N. S. staff writer in Columbus (Ohio) *Dispatch*, August 4.

ITEM XXIII

Federal Children's Bureau Versus Oregon State Medical Society

Provisions whereby the Federal plan for providing maternity financial assistance to wives of non-commissioned servicemen would be made acceptable to the medical profession in Oregon were rejected Tuesday by the Children's Bureau in Washington, D. C., in a telegram to Dr. J. F. Belz, director of maternal and child care for the Oregon Department of Public Health.

Crux of the situation is the determination of Oregon medical men not to be "blackmailed" into what they term bureaucratic regimentation of their profession.

The medical men approve of the plan to provide financial aid to the servicemen's wives who become mothers, but they object to the mechanics under which the plan is administered.

Fixed Fee Proposed

The funds have been provided by Congress for allocation by the Children's Bureau to the maternal and child care departments in the respective states.

Under terms of the rules laid down, hospitals would charge what is their own average fee for maternity cases, but there would be a fixed fee for the physician's services. As presently set up, this varies in individual states from $35 to $50. Cost would be borne by the Federal Government.

One of the stipulations in the plan is that the physicians agree not to seek or accept any additional fee in such maternity cases.

It is to this stipulation that the Oregon medical men object strenuously. It is not a matter of money, but it is the principle of the thing, they say—a government bureau telling them how much they may charge for services rendered.

Suggestions Offered

The Oregon State Medical Society's maternal and child care committee made known to Dr. Belz its suggestions in the matter, which were transmitted to the Children's Bureau. The medical men first suggested that a grant of money be made the expectant mother by the Government, and that she then be allowed to make her own financial arrangements with doctor and hospital.

The Children's Bureau has discarded this suggestion.

The Oregon doctors also asked that the requirement that they accept no additional fee in such a medical case be waived. The Children's Bureau rejected this request Tuesday.

"The medical profession has given assurance that adequate care will be given to the wives of servicemen, whether or not the plan is acceptable here, and whether or not the mothers have the funds for maternity care," a spokesman for the State Medical Society's committee on maternal care said Tuesday.

It was stated that the establishment of a fixed fee in a maternity case creates injustices as far as the physician is concerned because of the multiplicity of factors involved.

Standards for maternity care vary from community to community and among the doctors themselves, it was pointed out. Some physicians devote more time and attention to the mother before and after birth than do others, require more blood counts and other tests. They do not wish to and will not lower their standards regardless of what the fee is, physicians said. Moreover, the overhead costs of physicians vary from community to community, and within any one community, the doctors state, so that by all yardsticks it is unfair to set a fixed fee for maternal care.

A poll taken by the Oregon society showed that the physicians of the state are of the opinion that a fixed fee of $50 is entirely too low in view of their own time and expenses involved. Large numbers of them reported that such payment would represent a net loss to them.

Obstetricians said that 25 per cent of the babies born in the United States during wartime will be the children of servicemen.

The negotiations between the Oregon physicians and the Children's Bureau for some kind of settlement of the matter through the Oregon Department of Public Health will be continued, the spokesman for the medical society said.—*The Oregonian*, Portland, Oregon, August 18.

Los Angeles City Maternity Service

The Los Angeles City Maternity Service has been active since 1915, and is operated as a public health measure for the reduction of maternal and infant mortality, by the Los Angeles City Health Department.

It maintains antepartum and postpartum dispensaries, and provides for the conduct of labor in the patient's home (in suitable cases) under the supervision of the Director and the attending staff. At the present time, there are eight dispensaries in operation. Each patient is asked to go to her nearest dispensary, on the proper day, at least every two weeks throughout pregnancy. A complete physical examination including a blood test and a urinalysis is done on the first visit. A routine urinalysis and blood pressure are insisted upon at each subsequent visit. Most of the patients are referred to the clinic by the public health nurses, charitable organizations, clinics, hospitals and other similar agencies. A large number of patients are referred by "old patients." Each case is thoroughly investigated by the medical and nursing staff, to eliminate all cases able to pay for private care. The nursing staff is furnished by the Nursing Division of the Los Angeles City Health Department.

The location and hours of the eight dispensaries are as follows:

Temple Street Clinic, Wednesday, 9–11 a. m.

Southwest Clinic, Thursday, 9–11 a. m.

Watts Clinic, Monday, 9–11 a. m.

Griffin Avenue Clinic, Tuesday and Friday, 9–11 a. m.

Cedars of Lebanon Clinic, Thursday, 9–11 a. m.

West Los Angeles Clinic, Friday, 10–12 noon.

Van Nuys Clinic, Monday, 9–11 a. m.

San Pedro Clinic, Tuesday, 12:30–2 p. m.

A central office is maintained for the purpose of handling all routine clerical work, records, social service investigations, care of labor bags, obstetrical supplies, and many other matters which are routine in a large organization. A 24-hour telephone service is now maintained—MIchigan 5211, "Maternity Service."

We know that tuberculosis is caused by the tubercle bacillus, but we also know that malnutrition, fatigue, dust, poor ventilation, poverty, and overcrowding are contributing factors.—Henrietta Landau, Public Health Nursing Consultant, United States Public Health Service, *Hoosier Health Herald*, October, 1942.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Definition of Senate Bill 1161

Senate Bill 1161 is defined by its sponsors, Senator Robert F. Wagner of New York and Senator James Murray of Montana, as a bill:

To provide for the general welfare; to alleviate the economic hazards of old age, premature death, disability, sickness, unemployment, and dependency; to amend and extend the provisions of the Social Security Act; to establish a unified national social insurance system; to extend the coverage, and to protect and extend the Social Security rights of individuals in the military service; to provide insurance benefits for workers permanently disabled; to establish a Federal system of unemployment compensation, temporary disability, and maternity benefits; to establish a national system of public employment offices; to establish a Federal system of medical and hospitalization benefits; to encourage and aid the advancement of knowledge and skill in the provision of health service and in the prevention of sickness, disability, and premature death; to enable the several states to make more adequate provision for the needy aged, the blind, dependent children, and other needy persons; to enable the states to establish and maintain a comprehensive public assistance program; and to amend the Internal Revenue Code.

Introduced—U. S. Senate—June 3, 1943.

Read twice and referred to the Committee on Finance.

A Menace to Medicine

Hidden among the provisions of the Wagner-Murray bill to broaden the Social Security Act, which now is pending before the Senate, is one which effectually would destroy the free practice of medicine in the United States.

It would accomplish this by placing the entire medical profession, including its schools, hospitals, and clinics, under the direct or indirect control of the Surgeon-General of the Public Health Service, and by adding to the burden of the taxpayers the medical bills of some 110,000,000 people.

Under the system of socialized medicine which the Act would set up, the citizen would be deprived of his privilege of seeking treatment from a physician of his choice or at a hospital or other institution of his choice, and would be required to seek service from the doctor and institution indicated by the health service.

The goal at which the bill is directed—adequate medical service for all—is most commendable, and is one toward which the free medical profession long has been striving and hopes soon to reach.

But the socialistic approach of the Wagner-Murray bill is vicious, and every citizen should join with the medical profession in urging that the measure be rejected.—Editorial in San Francisco *Call-Bulletin*, August 10.

Comfort First

Another bill has been introduced in Congress—S. 1161—"To provide for the General Welfare." As usual, it is proposed to have the Federal Government do the providing. This most recent of the "comfort" measures is designed to remove virtually all the hazards of living. Among other things, it makes provision for free general medical, special medical, laboratory, and hospitalization benefits for more than 110,000,000 people in the United States. It would place in the hands of one man—the Surgeon-General of the Public Health Service—the power and authority to hire doctors and establish rates of pay for doctors; to establish fee schedules for services; to establish qualifications for specialists; to determine the number of individuals for whom any physician may provide service; to determine arbitrarily what hospitals or clinics may provide service for patients. In short, the bill, if enacted into law, would destroy the entire system of American medical care.

And so the specter of socialization à la the German pattern continues to haunt the land. On the one hand, we see a powerful labor union urging public ownership of basic industries, while on the other, public servants are recommending public ownership of the medical profession. Both moves are based on the fallacy that the general welfare is composed solely of two parts—comfort and security.

Our people would do well to remember the words of a famous writer: "If a nation values anything more than freedom, it will lose its freedom; and the irony is that if it is comfort or money that it values more, it will lose that, too."—Editorial in Salinas *Californian*, August 2.

Sickness-Insurance Bill Opposed by Physicians

With compulsory sickness insurance once more a national issue as a result of the introduction of the Wagner-Murray bill in this Congress, medical opponents of the measure are launching a drive against it bigger than any they have yet undertaken. Heading the opposition is the National Physicians' Committee for the Extension of Medical Service, with headquarters in Chicago.

The Committee regards this bill, which is expected to come up for discussion next winter, as by far the most dangerous proposal, from the standpoint of free economy, that has yet been made.

While the nature of the bill has caused some political leaders to regard it as too drastic for passage, medical critics of the measure are not trusting it to defeat itself. They say they intend to make known to the masses of people what it means in terms of their own pay checks, and their relations with the family doctor, and with their Government.

A great flow of pamphlets has been started from Committee headquarters informing people about the bill and stressing that the bill, if it were passed, would mean political medicine for the United States at an annual cost of $3,048,000,000. The Committee figures the cost to the individual family head would average $120 a year.

First Blueprint of Scheme

Introduction of the bill serves one useful purpose, as John M. Pratt, executive administrator of the National Physicians' Committee, sees it.

"For the first time," he said, "we are given in blueprint form the complete philosophy of the group favoring sickness insurance together with details for carrying it out—the mechanics of execution and administration. At last we know just what they propose."

Mr. Pratt says the proposal adds up to complete bureaucratic domination of the American people.

"If the recommendations of this bill are enacted into law," he declared, "they will destroy the private practice of medicine in the United States."

The Committee upon which Mr. Pratt serves has two main objections to the bill. First, as its members analyze it, it makes the Surgeon-General of the United States Public Health Service a virtual dictator.

"It proposes," says the Committee, "placing in the hands of one man—the Surgeon-General—the power and authority to hire doctors and establish rates of pay; to establish fee schedules for services; to establish qualifications for specialists; to determine the number of individuals for whom a physician may provide service; and to determine what hospitals or clinics may provide service for patients."

The second major objection of the Committee is to the cost of the service and the burden it would place upon the people forced to participate.

Cost Runs Into Billions

The Committee estimates that under the terms of the bill a minimum of $3,000,000,000 would be transferred from the Federal Social Insurance Trust Fund to the Medical Care and Hospitalization account each year. This is enough money to enable the Surgeon-General to pay for every available bed in non-government-owned hospitals at the rate of $5 a day, and for every bed in Government hospitals at $2.50 a day; to hire every effective physician in the nation at $5,000 per year; to spend a sum of something over $168,000,000 a year for drugs; and still to have $600,000,000 for administrative costs. In addition, says the Committee, the bill provides a fund for medical education. With this money, as the Committee also estimates it, the Surgeon-General could assume the total cost of operating the sixty-six accredited medical colleges of the United States, provide scholarships of $700 for 22,000 medical students; and still have about $11,000,000 left for research.

For Doctor, "Abject Slavery"

While these expenditures seem extravagant to the Committee, its members object to the bill more on the ground of its probable effect on the medical profession than on its cost.

"State medicine—political control of medical service," the booklet states, "always has meant, always will mean, for the mass of people medical care through and by physicians who are politically amenable rather than by those with superior abilities and skills.

"For the doctor, State medicine means abject slavery. . . ."

The Committee figures it will take about 150,000 persons to administer the Act—to "tell patients where to go and doctors what to do." This, it believes, will establish a new class of people with a vested interest in the perpetuation of sickness insurance.

The Committee reports it is getting an enthusiastic response from many of those to whom it has sent its literature, including 131,000 doctors. — *Christian Science Monitor*, August 18.

A Fight for More Security

Federal Medical Benefits Stir Up Strong Opposition

Washington, August 19.—The Wagner-Murray-Dingell bill, now pending in Congress and proposing a great extension of the Social Security system, uses nineteen of its ninety pages to outline legislatively what it calls "Federal medical, hospitalization and related benefits"—an enterprise which some opponents describe as "socialized medicine," and which an unfriendly organization of physicians calls "totalitarian medicine."

This is probably the most controversial part of the bill. Its advocates see in it a blessing for the millions of low-income families whose members delay or neglect visits to physicians and hospitals because of the cost.

Its foes say it would "abolish private medical practice" and set up a vast new bureaucracy under which the head of the Public Health Service, with three billion dollars a year to spend, would eventually become the employer of all the physicians in the country and the controller of all hospital beds.

"For the doctor," says the National Physicians' Committee for the Extension of Medical Service, "state medicine means abject slavery—the necessity of catering to the ward committeeman or the precinct captain rather than to the needs of the human beings who are his patients."

However, doctors are divided. Some nationally prominent physicians support the general principles of this proposed legislation, and through their Committee of Physicians for the Improvement of Medical Care, Inc., have said it "provides a framework and a basis for discussion from which it is sincerely hoped that a constructive program for improved medical and health care of the American people may be developed."

Dr. George E. Bigge, Social Security Board member, says: "There is nothing in our recommendations, or so far as I can see in the Wagner-Murray-Dingell bill, which would in any way affect the doctor or the hospital in their relations with their patients. The purpose of the proposal is simply to make sure that patients will have the money with which to pay their bills. I can see no reason why any physician should object to that."

The American Federation of Labor description of the proposed new health insurance program is that it would extend "medical and hospital care to all persons covered under old-age and survivors' insurance and for their dependents. The benefits include necessary general and special medical services, hospitalization and related medical services, supplies and commodities. Technical and professional administration is lodged with the United States Public Health Service. . . .

"The bill assures free choice of any regularly licensed general practitioner, arrangements for use of specialists' services, and varied methods of remunerating doctors, with emphasis on maintenance and development of the quality of medical care, and provision for grants to aid medical education and research."

The National Physicians' Committee declares, "The provisions are so sweeping that, if enacted into law, the entire system of American medical care would be destroyed."

This committee says the bill would place in the hands of one central authority, the Surgeon-General of the United States Public Health Service, "authority (1) to hire doctors and establish rates of pay, possibly for all doctors; (2) establish fee schedules for services; (3) establish qualifications for specialists; (4) determine the number of individuals for whom any physicians may provide service; (5) determine arbitrarily what hospitals or clinics may provide service for patients."

Says the A. F. L. Committee on Social Security, "We have no desire to interfere in the scientific matters of the medical profession, in which doctors alone are competent, but we are concerned to make medical care available to those who need it."

As to the other end of the plan, the A. F. L. committee says, "Voluntary hospitalization covers around ten million people, while hospitalization insurance under Social Security should cover something like 80 to 100 million."

Apparently the A. F. L. doesn't expect to get this benefit immediately, for it says: "Of course, the nation cannot put a comprehensive national medical-care program into actual operation during the war while so many doctors are with the armed forces, but we can begin to lay plans and build up the insurance end."

It says, also: "A hundred years ago, after we had achieved universal manhood suffrage, the American labor movement struggled to secure universal public education. That education has been a source of our national strength. Now that we have begun to build Social Security we can further strengthen our nation by a program of national health through medical-care insurance."—San Francisco *News*, August 19.

Additional United States Aid

Public Backs Bill: Gallup

Princeton, N. J., Aug. 17.—Eight years ago, on August 19, 1935, President Roosevelt signed a bill which was destined to become one of the most popular and best-liked single pieces of legislation in the history of the New Deal.

The eighth anniversary of the Social Security Act finds a number of basic amendments pending in Congress which would greatly broaden the scope of the Social Security program. The public, which approved the original act by the overwhelming vote of 89 per cent, is in favor of many of the proposed amendments, and a substantial number of Americans are willing to pay 6 per cent on their wages and salaries in order to make the enlarged program possible.

An Institute survey from coast to coast put the issue before the people as follows:

"At present the Social Security program provides benefits for old age, death, and unemployment. Would you favor changing the program to include payment of benefits for sickness, disability, doctor and hospital bills?"

The vote is:

	Per Cent
Yes	59
No	29
Undecided	12

All those who favor the program were then confronted with the fact that this would mean an increase in the amount of money deducted from their wages or salaries. They were asked whether they would be willing to accept this larger deduction:

"Would you be willing to pay (or have your husband pay) 6 per cent of your salary or wages in order to make this program possible?"

The vote of the 59 per cent approving the program divides as follows:

	Per Cent
Yes	44
No	11
Undecided	4

Another of the many proposals contained in the bill now before Congress is that Social Security be broadened to include farmers, domestic servants, Government employees, professional persons and others who are not now included under the program.

By a large vote the public favors expanding Social Security to include these groups:

"At present farmers, domestic servants, Government employees, and professional persons are not included under Social Security. Do you think the Social Security program should be changed to include these groups?"

	Per Cent
Yes	64
No	19
Undecided	17

—George Gallup, Director, American Institute of Public Opinion, in San Francisco *News*, August 17.

Social Security Should Include Hospitalization Insurance: Report of an A. F. L. Committee

Continuing its series of articles in support of proposed amendments to the Social Security law, the American Federation of Labor committee this week declares the law should be amended to include insurance for paying hospital bills. The committee signing the articles consists of Matthew Woll, George Meany, G. M. Bugniazet, and John P. Frey.

The worst thing about a hospital bill, the Committee states, is that one can never know when such a bill may have to be incurred. A family may go along for years with almost no sickness, then one child may have a ruptured appendix and another may have to go to a hospital for other serious illness, and even a reasonable hospital bill might run up to a large part of the wage-earner's yearly salary. And no matter how generous the terms of payment on installments, yet the family earnings may be mortgaged far into the future and with no reserve accumulated for the next sickness.

Some Potential Benefits

People protected by hospitalization insurance could go to the hospital as soon as the doctor found it advisable. Physicians often hesitate to send a patient to the hospital because of the expense involved. With insurance, sick people also can stay in a hospital instead of leaving too soon in order to hold down expense. Such social insurance would not cover the doctor's bill, but it would reduce the cost of sickness by paying all or a portion of the hospital charges. Under a system of hospital insurance none would have to ask for charity care during an illness.

The A. F. L. committee points out that a nation or any large group can make fairly accurate prediction of what sickness may occur in a year; but a family cannot do so. A nation can estimate its hospital costs for a year, add a reserve for contingencies and then figure out an insurance program, prorating the costs as premium payments among the insured people or families. The insured person who has no hospital bill for some years is doubly lucky in that he has his health and a feeling of safety that his hospital bill would be paid if he should become ill. In other years his hospital bill might exceed more than he had paid into the fund over his many healthy years. The Committee statement continues:

Would Aid the Hospitals

"Hospitalization insurance helps the hospital as well as the patient. This is very important, for many fine hospitals are handicapped by lack of money. A hospital must provide room and board suited to the special needs of each patient. It must have nurses and doctors who have taken long and expensive training to fit themselves for the work. Its equipment and upkeep are very expensive. Every empty hospital bed is a loss. The more patients a hospital has (up to its capacity) and the more completely its regular and special services and equipment are used, the lower it can make the charges to each patient, and the better the service it can give for the money."

Hospitalization insurance provides for paying hospital bills at once, instead of their deferment. It simplifies the patient's entrance for treatment, doing away with the down payment. Even limited insurance that pays only for hospital bed and board would keep and help both the hospital and the patient. Many people could find the money to pay for other hospital costs, the committee report states, and further, insurance benefits will help hospitals in small communities to build themselves up to the people's needs.

The proposal for hospitalization insurance, the Committee reminds, does not contemplate doing away with private hospitalization plans. It cites that some of these, like the Blue Cross plan, are doing fine and useful work. Some private plans, however, are not managed well enough, or not free from exploitation to give the kind of protection the members pay for. Also, social insurance does not aim to cover all hospital expenses, but only to lighten the burden for basic costs. One can carry private insurance to take care of the extra charges as wages are increased—"just as we have increased our private insurance and have had more appreciation of our union insurance since we have had social security."

It is further presented in the committee report that whereas voluntary hospitalization now covers around ten million people, such insurance under Social Security should protect something like eighty to one hundred million. And: "Hospitalization insurance under Social Security can cover the entire family. For the same costs it can give more days of hospitalization because it can operate as part of the going Social Security system, using the same records and overhead administration. . . . You can get more hospitalization insurance for the money under Social Security than you can get in any private plan which you join as an individual; and if you are protected at low rates under a group plan, perhaps through your plant, you are only eligible for that hospitalization insurance as long as you work in that plant."

Exclusion of Occupational Injuries

Concluding the current article in the series (which will yet have five more installments in relation to the various proposed amendments to the Social Security law) the A. F. L. committee declares that hospitalization insurance should be provided for all workers now covered by old-age and survivors' insurance, their families and dependents. But to avoid interference with workmen's compensation, occupational injuries should be excluded from the plan. Insurance benefits, the Committee declares, should pay hospital bills of from $3 to $6 a day, or else reasonable hospital costs. Each injured person and each of his dependents should have as many as thirty days of hospitalization a year, and if the insurance funds permit, each might have up to sixty days. "Most of us won't need anything like that much care; but think what it will mean to those who do need it!"—San Francisco *Labor Clarion*, August 6.

Wagner-Murray-Dingell Bill (S. 1161): How Minnesota State Medical Association Representatives Met with Mid-West Congressmen

(COPY)

MINNESOTA STATE MEDICAL ASSOCIATION
Saint Paul, Minnesota,
August 11, 1943.

Dear Doctor:

I am sending you herewith for your information a notice which went to our membership recently about an unusual conference now being arranged between professional groups and the Senators and Congressmen from five states in this section.

This is the first conference of the sort anywhere in the country, but we understand that others are under consideration and that representatives from other states will be here to observe and assist in organizing similar meetings if this one is a success.

In view of the fact that several proposals for radical expansion of social security in this country are now before Congress, such contacts with Senators and Representatives may well be of critical importance to the future of medical practice.

A statement representing the views of the medical profession of the states covered, including Wisconsin, Iowa, North and South Dakota, and Minnesota, will be presented to the members of Congress as a feature of the formal program. It will be followed by a question and answer session.

We shall be glad to send you a report of the proceedings if you are interested in arranging a similar conference in your section.

Sincerely yours,
(Signed) R. R. ROSELL,
Executive Secretary.

* * *

SENATORS AND CONGRESSMEN TO TALK THINGS OVER WITH NORTHWEST FARMERS, BUSINESS AND PROFESSIONAL MEN

What will probably be the largest and most significant conference ever held between members of Congress and their constituents back home is now being planned for Monday, August 16, at the Radisson Hotel in Minneapolis. Three sessions are being arranged. . . .

Twenty-five Senators and Congressmen have already accepted invitations to be present. . . . They are from the following states: Minnesota, Iowa, Wisconsin, North Dakota, and South Dakota.

These are momentous times in the life of the nation, and especially for the profession of medicine.

Before Congress today is the revolutionary Wagner-Murray-Dingell "cradle-to-the grave" legislation which calls for a complete recasting of medical service, including compulsory sickness insurance, in this country. Before it are innumerable problems involving the health of the nation and stemming from the shortages and stringencies of war.

These are the men in whose hands the decision will rest as to the future of medicine in the United States.

Says Congressman A. H. Andresen of Minnesota of the conference: "This will be a meeting where Congressmen and Senators will be the listeners and not the speakers. They are anxious to ascertain the sentiment and feeling of the people, in an effort to secure information on the effect of present policies on business, the professions, and farming, in order to legislate more intelligently when Congress reconvenes on September 14. The Radisson Hotel conference is in harmony with the intent of the Congressional recess which was to give members of Congress an opportunity to talk with their constituents."

Make your plans now to attend the evening meeting!

R. R. ROSELL, *Executive Secretary,*
Minnesota State Medical Association.

* * *

Home Front Demands Listed

Minneapolis, Aug. 18 (AP).—Representative August H. Andresen (R., Minn.), chairman of a conference of Congressmen and citizens on Washington's administration of the home front, said today the opinion of speakers "clearly demonstrated a common problem—unwise and detrimental rule by Washington bureaucracy."

He listed as demands of the speakers for farm, business and professional groups:

1. That Congress recover the legislative powers heretofore granted to the Executive.

2. The discharge of hundreds of inexperienced policy-making bureaucrats, to be replaced by experienced men from agriculture, business, and professions.

3. The cancellation of federal policies which are now crushing business and jeopardizing the production of food.

At the two-day conference were sixteen Congressmen—fourteen Republicans, a Progressive, and Farmer-Laborite—and representatives of the farmer, business, and professional man. Andresen estimated the total attendance of four sessions at 2,500.

The conference was called, Andresen said, after several Northwest trade groups asked him to organize a meeting so farmers, business and professional men could appear personally before the Congressmen while they were on their home grounds and tell of their troubles with directives and personnel of Washington home front war bureaus. Congress is in recess until September 14.—San Francisco *Call-Bulletin*, August 18.

COMMITTEE ON INDUSTRIAL PRACTICE

California Industrial Accident Fee Schedule

Attention of California Medical Association members is again called to the following:

Dear Doctor:

Have you mailed in your postcard on Industrial Accident Commission fees?

We need every one we can get. If you haven't sent yours in already, *please do it now.* If you have mislaid the card, write the California Medical Association office for another one.

If you have sent in your card, many thanks. In that case, won't you make it a point to contact at least three of your colleagues and make sure that their cards have also been sent in?

Let's all pull together on this—for the good of all.

Karl L. Schaupp, M. D.,
President, California Medical Association.

A Committee on Industrial Health in the Medical Society of Every Industrial County

An active local industrial health program should be based on:

(*a*) Local industries' medical needs.

(*b*) Telling industry and labor what needs to be and what can be accomplished under existing conditions.

(*c*) Lining up the physicians willing to help and teaching them how to do it. This can be done by special or county society meetings devoted to industrial health. Suggested subjects:

1. Minimum standards of industrial health today.
2. Duties of physicians in small and large industrial plants.
3. Preplacement and periodic physical examinations in industry.
4. Health education and consultation in industry.
5. Rehabilitation of war casualties in industry.
6. Control of occupational diseases.

(*d*) Organizing a coöperative program between the medical society, industry and interested agencies to further the program.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Purpose of the Public Health League of California

1. To preserve a proper relationship between the patient and his physician, dentist and nurse.

2. To educate the public to the proper evaluation of medicine, dentistry, nursing and the allied sciences.

3. To make social, economic and legal studies pertaining to the preservation of the public health, and the care and treatment of the sick and injured.

4. To gain the enactment of laws, affecting the greater usefulness of ethical medicine, dentistry, nursing and the allied sciences.

5. To protect the public health by opposing objectionable forms of medical, dental and public health legislation.

6. To protect the public against quackery, patent nostrums, fraudulent advertising and the medical practices of unqualified persons and groups.

7. To support public health departments, ethical hospitals, pharmacists, laboratories and other qualified agencies in their efforts to reduce the prevalence of disease and disability.

8. To protect qualified persons, institutions and agencies engaged in the care and treatment of the sick, against unjust encroachment upon their functions and activities.

Health of United States Remains Good

Mortality Rate Declines in Year

New York, Aug. 10.—"America at war continues in good health," statisticians of the Metropolitan Life Insurance Company here report in a summary of mortality experience of its millions of industrial policyholders in the nineteen months since Pearl Harbor.

In 1942 the mortality was the lowest ever recorded for any year. Although the monthly death rates have been higher each month this year than for the preceding year, the rate for the first six months of 1943 is only 7 per cent higher than for the same period in 1942 and appreciably lower than in any year before 1938.

Aside from the mounting toll of war deaths, the only other unfavorable features are the higher-than-ever-before death rates from cancer, cerebral hemorrhage and diseases of the heart and arteries.

Gasoline rationing has rolled back the auto accident death rate to 11.6 per 100,000 population, which is about what it was for the first half of 1922, and 37 per cent below the first half of 1942.

American women, now playing an important rôle in war production, are healthier than ever. In the two years before our entry into the first World War the death rate among the company's women industrial policyholders was thirteen in every 1,000 of ages 15 to 74 years, while in the 1940-1941 period it was less than half that, seven per 1,000.

Married people, the statisticians find, live longer, this being especially true for married men. At ages 30 to 44 years the death rates among married men are just about half those among the bachelors. Between 1929-1931 and 1939-1941 the death rates declined somewhat more rapidly among the married than among the single at ages under 40 years.

Those whose marriage is broken by death, however, experience a mortality even higher than those who remain single. Here again the men are slightly worse off than the women.—Science Service in San Francisco *News*, August 10.

Medical Group Reports Gain in Polio Cases

Chicago, Aug. 17 (AP).—The American Medical Association today reported an "alarming increase" of infantile paralysis in widespread sections of the country.

The A. M. A. *Journal* said the disease may become more prevalent this year than at any time since 1940, when 9,770 cases were recorded.

"Through August 7 nearly 3,000 cases have been reported," the *Journal* said, "or more than twice as many as appeared during the similar period last year."

Kansas Outbreak

California, Texas, Oklahoma and Connecticut appear to be most seriously affected, the *Journal* said. Recent reports, however, said Kansas is suffering the worst infantile paralysis outbreak of its history, with a peak expected some time next month.

The National Foundation for Infantile Paralysis notified Governor Andrew F. Choeppel that it was placing every resource, including money if necessary, at the disposal of Kansas physicians and public health authorities.

Epidemic Proportions

In the Chicago area the spread of the disease was reaching the epidemic proportions with ninety-three cases reported this year. The total for Illinois was 134 cases, with nineteen fatalities.

California recorded 111 new cases the week ending August 7, bringing its total for the year to 952.

Other states reported the following totals through August 7:

Texas, 757; Oklahoma, 292; Kentucky, 51; Alabama, 46; Connecticut, 41.—Modesto *Bee*, August 17.

Venereal Disease Control Center in San Francisco Considered

A big step in the control of venereal diseases—establishment in San Francisco of a rapid-treatment center for the cure and rehabilitation of infected women from northern

California—is under consideration by United States and State health officials, the *News* learned today.

The project, part of nation-wide pattern to wipe out prostitution and promiscuity wherever there are large concentrations of military and civilian personnel, will be financed from the emergency fund set up by the Lanham Act, and, if established, will be operated by the State Department of Health, with local health authorities acting in an advisory capacity.

Although Federal, State and local officials were unwilling to make a general announcement of the center "because there are so many things to be ironed out yet," they agreed that the project was inevitable for the Bay Area, that Federal funds were available, and they were now in the process of studying locations. . . .

With all the "ifs" taken into consideration, the San Francisco center could probably be ready for occupancy by January 1. Its probable cost would be over $350,000 a year.

San Francisco was chosen as the location—against the opposition of many factions—because it has been estimated that of the 200 women the center expects to treat, 100 would come from here, seventy-five from the East Bay and twenty-five from other northern California localities.

This center is not the first in the country by any means; this area has been slow to fall into line with thirty-seven others already in operation, thirteen approved and seven pending. Los Angeles has been operating a rapid-treatment center on medical lines—which this one hopes to keep away from—in its county hospital setup. Twenty-two additional centers, of which San Francisco is one, have been proposed by the Government.—Dorothy Walker in San Francisco *News*, August 7.

Prevalence of Disease

No health department, state or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring.

Reports from States for Week Ended July 31, 1943: Summary

A total of 361 cases of poliomyelitis was reported for the current week, as compared with 329 for the preceding week and a five-year (1938-42) median of 146. The current excess incidence of the disease continues to be confined to a few states, 75 per cent, 269 cases, of the total number being reported in four states, as follows (last week's figures in parentheses): Texas, 105 (96); California, 104 (111); Oklahoma, 30 (42); and Kansas, 30 (7). No other state reported more than eleven cases. The cumulative total for the first thirty weeks of the year is 2,316, more than for the corresponding period of any other year since 1934, when 3,180 cases, only 44 per cent of the year's total, had been reported, although the peak of weekly incidence had been reached with a report of 376 cases in the third week of June. The peak of the 1938-42 weekly medians, 501 cases, occurred during the third week of September.

A further reduction in the incidence of meningococcus meningitis was recorded for the week, although the total of 203 cases reported, as compared with 237 for the preceding week and a median of 31, is nearly three and one-half times the average for the corresponding weeks of the past fifteen years. The cumulative total for the first thirty weeks of the year is 12,981, as compared with 7,720 in 1929, the largest number recorded for the corresponding period of any prior year.

Of the seven other common communicable diseases included in the table, and for which prior comparable data are available, the incidence of only influenza increased as compared with the preceding week, and the totals of only influenza, measles, and whooping cough were above the corresponding median figures.

Deaths recorded for the week in ninety large cities of the United States totaled 8,305, as compared with 8,217 for the preceding week and a three-year (1940-42) average of 8,289. The accumulated number for the first thirty weeks of the year is 284,120, as compared with 258,770 for the same period of last year. . . .—*Public Health Reports* of United States Public Health Service, August 6, 1943.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

United States Nurse Cadet Corps*

Surgeon-General Parran Arriving to Help Form Cadet Nurse Corps

America's hospitals have the greatest overload of patients in their history, Dr. Thomas Parran, Surgeon-General of the United States Public Health Service, said yesterday, even though America's general health is "good."

Doctor Parran, here to help organize the new United States Cadet Nurse Corps, blamed three factors for the surge of patients to hospitals:

1. Busy doctors don't have time to drive from house to house.

2. Patients can't get nurses for home duty.

3. Crowded housing conditions in war-boom areas make medical treatment difficult. Trailer camps and rooming houses jammed with many families are not fit places for care of the sick.

Problem Acute

"The civilian medical problem is acute, with the military forces taking doctors and nurses," Doctor Parran said. "Nursing care has deteriorated in the last few years and is at the danger level in many communities."

The shortage of nurses has forced many hospitals to turn away from their doors patients with serious trouble, Doctor Parran explained, while some institutions have closed entire wards.

In other cities whole hospitals have been offered to the Government," he declared, "although they are sorely needed for medical care."

The Surgeon-General said that Congress passed the Bolton Act July 16 to prevent collapse in the hospital system. This establishes the Cadet Nurse Corps, which this year is expected to recruit 65,000 new student nurses between the ages of 18 and 35.

Poliomyelitis Spread

Doctor Parran said the spread of poliomyelitis has not been as heavy as was feared. "California has been harder hit than any other section of the country, with Texas next," he declared, "but there have been no substantial outbreaks elsewhere."

Arriving by Union Pacific from Washington, Doctor Parran was accompanied by Miss Lucile Petry, director of the Division of Nurses Education of the Public Health Service. They conferred with Dr. Walter L. Treadway, the Public Health Service's medical director here; Dr. Wilton L. Halverson, State health officer, and many other medical officials.

Guest at Luncheon

Doctor Parran was a guest of Dr. Rufus B. von KleinSmid, University of Southern California president, at a luncheon in the California Club, where he is stopping, and in the evening made an off-the-record address to the Los Angeles County Medical Association.

In the afternoon he and Miss Petry spoke at a California Hospital meeting, sponsored by the American Hospital

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* For editorial comment, see page 155.

Association and the National Nursing Council for War Service.

They listed California's goal as 4,500 student nurses this year for a reserve to replace the 2,500 nurses needed every month by the armed forces. Thirty-five thousand nurses already have entered the armed services, creating the serious shortage in civilian hospitals and agencies.

Training Offered

High school graduates, married or single, are offered free professional education in nursing schools at six Los Angeles hospitals, with the Government paying full tuition and fees and providing a monthly stipend and uniforms during the accelerated training period. Civilian hospitals are expected to retain the majority of students after their graduation.

Ritz E. Heerman, California Hospital superintendent, who presided at the recruiting meeting, said the nursing schools participating are at the Good Samaritan, California, General, Queen of Angels, St. Vincent's, and White Memorial hospitals in Los Angeles; at the Huntington Memorial in Pasadena and at the Glendale Sanitarium and Hospital. Any hospital can provide full details on the course.—Los Angeles *Times,* August 27.

The Family Physician and the United States Cadet Nurse Corps

Dr. Thomas Parran, Surgeon-General of the United States Public Health Service, stated that the needs of the war effort make imperative a considerable increase in the numbers of nurses for essential civilian and military nursing services. To aid in meeting this need, the Congress, in passing the Bolton Act, has created the United States Cadet Nurse Corps.

It is natural that young women who contemplate joining the Cadet Nurse Corps will turn to the family physician for advice and guidance on this matter. In pointing out to the prospective cadet nurse some of the reasons why she is needed and how joining the Corps will benefit both herself and her country, the physician on the home front will be making still another patriotic contribution to the prosecution of the war. Furthermore, it is to the physician's own interest to stimulate recruitment, since as his load of work becomes heavier, nurses can be of increasing assistance to him not only in hospitals, but also in his office and in his patients' homes.

To aid the physician in giving counsel which is specific and which will lead to action on the part of the Cadet Nurse candidate, the following suggestions are offered.

The Bolton Act.—In essence, the Bolton Act provides for grants-in-aid to nursing schools whereby the student nurse is relieved of the burden of tuition, fees, and other expenses which she ordinarily would have to meet herself, and, in addition, she is paid a monthly stipend. Schools participating in the program will continue to select their students and to plan and operate their own curricula. . . .

The effect of the Bolton Act will be to produce more nurses by stimulating recruitment of students and by speeding up training. Recruitment of student nurses has met severe competition from the many opportunities available at present to high school graduates, especially in the uniformed services and in war industry, where pay is immediate without further training. Allotments of funds to the nursing schools will aid in meeting this competition, and will further assist the schools in accelerating their curricula so that training will be more rapid.

Financial Freedom.—Full tuition and maintenance, including the uniform, are furnished the cadet and, in addition, she receives a regular monthly stipend which, although too small to attract those interested primarily in monetary return, is yet sufficient so that no girl need be deterred by financial obstacles from seeking a nursing education. Stipends will amount to $15 per month during the first nine months of training, $20 during the next fifteen to twenty-one months, and $30 or more for the six to twelve months remaining before graduation.

Choice of School.—The prospective cadet is free to enter the nursing school of her choice, provided only that the school is participating in the program, and that she herself is able to meet the scholastic, personal, and physical requirements of that school.

Choice of Job.—While the cadet is required to agree that after graduation she will continue in essential nursing for the duration of the war, it is to be emphasized that she is not compelled to enter military service. On graduation she is free to choose among the military services and numerous civilian nursing activities. It is to be noted that Army nursing and many civilian positions are open to married nurses. Whether or not a cadet may marry during her training is dependent entirely on the regulations of the school in which she is enrolled.

Joining the United States Cadet Nurse Corps:

Application to Nursing School.—The young woman who is interested in joining the United States Cadet Nurse Corps should inquire from the nursing school of her own choice as to whether it is participating in the program. She must be a high school graduate; other admission requirements vary among individual schools.

Choice of School.—It is suggested that it may be recommended to prospective cadets that they obtain catalogs of at least three schools before making a final selection. A booklet, entitled "Nursing and How to Prepare for It," will prove helpful to young women and may be obtained free from the National Nursing Council for War Service, 1790 Broadway, New York, New York.

Lists of Nursing Schools.—Lists of the 1,300 nursing schools in the United States which are accredited by State Boards of Nurse Examiners are also available from the National Nursing Council for War Service. The State Board of Nurse Examiners can supply a list of the schools in each state.

Additional information may be found in *The Journal of the American Medical Association* for March 27, 1943, and July 10, 1943, on p. 752.

Nurses' Fee Schedules: Los Angeles Area

The Nursing Bureau Committee of the Los Angeles Nurses' Association announces the following schedule of fees as approved by vote of the Private Duty Section in August, to be effective September 1, 1943.

General Nursing Care

In Hospitals.—Eight dollars for eight hours; one dollar for each additional hour.

In Homes.—Eight dollars for eight hours; $11 for twelve hours. In homes, a nurse should receive one meal for eight hours and two meals for twelve hours. Actual nursing service over a 24-hour period shall not exceed twelve hours.

Extra Charges.—One dollar additional will be charged for the care of the baby in obstetrical cases. Three dollars for each additional patient in the hospital and homes. One dollar additional will be charged for cases in the C. D. Department of the Los Angeles County General Hospital and quarantined in homes and other hospitals. Maximum fee for above rates not to exceed $12 for eight hours.

Acute Alcoholism.—Nine dollars for eight hours. $1.25 for each additional hour. Maximum fee not to exceed $15.

Psychiatric.—Violent maniacal, violent suicidal, and violent patients in restraints, $9 for eight hours, $1.25 for each additional hour. Maximum fee not to exceed $15.

Home Cases.—Mileage rate on bus or street car exceeding thirty cents round trip may be charged to the patient.

Transportation to out-of-town cases and local cab fare for calls between 12 (midnight) and 6 a. m. are the responsibility of the patient calling the nurse.

When order for a nurse is canceled after arrival on a case, the nurse is entitled to one-half day pay.

Hourly Nursing.—Two dollars for the first hour or fraction thereof. Fifty cents for each succeeding one-half hour not to exceed three hours. Beyond a radius of five miles from the nurse's home, mileage at five cents per mile will be charged.

Daily Staff Relief.—Fee for daily staff relief by private duty nurses to be at the prevailing rate for private duty services based on $8 for eight hours for fourteen days—for more than fourteen days, based on monthly staff salary—employment for fifteen days or more to be stated at time arrangements are made with nurse.

Nurses' Aides Are Eligible for Civilian Security Benefits

All volunteer nurses' aides should be enrolled in the U. S. Citizens Defense Corps, the Medical Division of the Office of Civilian Defense states in a special announcement, Circular Medical Series No. 32.

The Circular explains that questions persist in some localities regarding enrollment, particularly of nurses' aides not specifically assigned to Mobile Medical Teams, Casualty Stations, and other field casualty units of the Emergency Medical Service.

The immediate importance of this announcement lies in the fact that nurses' aides must be enrolled in the Nurses' Aide Unit of the Citizens Defense Corps, if they are to be eligible for the benefits provided under the War Civilian Security Program of the Federal Security Agency for all members of or trainees for the Citizens Defense Corps who may be injured in line of duty. Nurses' aides presently working in hospitals and health agencies are considered to be in training for service in care of the wounded in the event of an enemy attack or other wartime disaster. They are, therefore, eligible for membership in the Defense Corps, and are thus eligible for the benefits of War Civilian Security after enrollment. . . .

Hospital Employees Declared Essential

The recent Presidential Order with reference to the job stabilization program needs to be emphasized to our workers and the people of this community.

1. Hospitals are classified under the Section on Health and Welfare Services. Therefore, the hospital and all of its employees come under the job stabilization plan.

2. The Hospital Management and the employees are asked to comply with this order. Severe penalties are invoked on all parties for failure to carry out the program.

3. The order restricts the employee from henceforth changing his position without obtaining a certificate of availability through the War Manpower Commission. This must be done with the consent of the employer, unless the Commission rules otherwise after a hearing has been held.

4. The Hospital Management will be permitted to employ only those persons who present availability certificates from the War Manpower Commission. The hospital cannot issue availability certificates except for good cause.

The Executive Medical Board has noted this order and asked that it be posted for the information of all the doctors on the staff of the California Hospital, as the doctor's office also comes under the Section on Health and Welfare Services, and they are violating the law if they give employment to an employee from the hospital without first securing an availability certificate from the hospital. As the hospital cannot issue these availability certificates, except for good cause, it is important that the doctors do not offer positions to hospital employees until they have consulted the Hospital Management.

Employees of physicians' offices, including office workers, nurses, and technicians, regardless of the number, are also declared essential and come within the regulations of the War Manpower Commission.

Physicians who do not wish to sign up with the local Manpower Commission program automatically come under the national program known as Regulation 904.

It is advisable for physicians to acquaint themselves with these regulations.

(Signed) Benjamin H. Hager, M. D.,
Chairman of California Hospital Staff.

1414 South Hope Street, Los Angeles.

Change Sought in Hospital Pay Rule

Dr. Paul A. Dodd, associate public member of the War Labor Board, has left for Washington, D. C., to seek a change in WLB salary level regulations to give proprietary hospitals the same status as nonprofit hospitals, the Association of California Hospitals announced today.

The change, requested at recent meetings of hospital administrators and nurses' representatives here and in Los Angeles, would permit proprietary hospitals to increase pay to the approved salary levels without first securing WLB authorization, officials of the Association said. Nonprofit hospitals now are permitted to follow this policy. WLB officials said, however, salaries of general duty nurses in hospitals under WLB jurisdiction cannot be increased beyond the approved monthly level of $140 to $150.—San Francisco *News*, August 30.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (10)

Alameda County (1)

Kameny, Louis, *Oakland*

Monterey County (1)

Duey, Harold Albert, *King City*

San Francisco County (4)

Hall, Donald Thornton, *San Francisco*
Lawson, Wallace Robert, *San Francisco*
Nickels, Thomas Tanton, *San Francisco*
Sawin, John Frederick, *San Francisco*

San Mateo County (2)

Harris, Maxwell, *Burlingame*
Sears, David, *Belmont*

Solano County (2)

McVeagh, Thomas Cochrane, *Vallejo*
Torrance, Susan E., *Oakland*

In Memoriam

Gay, Eugene John. Died at Stockton, June 21, 1943, age 72. Graduate of Drake University, College of Medicine, Des Moines, 1897. Licensed in California in 1912.

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† For roster of officers of component county medical societies, see page 4 in front advertising section.

Doctor Gay was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

* * *

Harwood, Dorsey Alford. Died at Santa Ana, July 17, 1943, age 64. Graduate of the University of Illinois College of Medicine, Chicago, 1906. Licensed in California in 1920. Doctor Harwood was a member of the Orange County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

* * *

Keating, Vincent J. Died at Los Angeles, July 31, 1943, age 58. Graduate of Chicago College of Medicine and Surgery, 1909. Licensed in California in 1924. Doctor Keating was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

* * *

Pond, Samuel Benjamin. Died at Patton, July 20, 1943, age 61. Graduate of the University of Minnesota College of Homeopathic Medicine and Surgery, Minneapolis, 1907. Licensed in California in 1918. Doctor Pond was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARIES

Julian Mast Wolfsohn

1883–1943

That patients, colleagues, and friends in all walks of life should unanimously come forward to express their grief at Julian Wolfsohn's death is greater testimony than written words of the magnitude of his loss.

Born in San Francisco in 1883, Wolfsohn was educated in the public schools and was graduated from the University of California in 1905 with the degree of A.B. in Science. In 1911 Wolfsohn completed his course in medicine at Johns Hopkins. Standing high in the class, he won one of the coveted medical internships, which he held from 1911-1912. On his return to San Francisco his interest in neurology, already evident in student days, led to his appointment as instructor at Stanford. He was still on the staff at the time of his death, with the rank of clinical professor. In 1917 Wolfsohn promptly entered the Army and in April was commissioned Captain in the Medical Corps. In September, 1919, he was retired from the Army with the rank of lieutenant colonel, but he returned almost yearly to London and Paris for study.

In 1933, at the height of his career, a mounting hypertension with severe general symptoms and finally a coronary occlusion drove him to have a splanchnic section—an operative procedure at that time still in the experimental stage. The result was brilliant, with restoration of an almost normal blood pressure and relief of symptoms. Some permanent impairment of strength, however, called for constant safeguarding by a devoted household; but at the time of his death from acute intestinal obstruction he was working hard in his very best form.

Julian Wolfsohn had a colorful personality combined with a wide and philosophic outlook on life. His magnetism was such that he was almost always the center of the group while others listened with interest that rarely flagged. A brilliant teacher, he was devoted to the students. They were often in his home, and his many individual acts of help and kindness remain largely unrecorded. As a practitioner he had that rare combination of sound background together with the practical knack of dealing with patients—especially necessary in his type of work. Many of the most difficult psychiatric problems were loaded on his shoulders; the needed help rarely failed to materialize. Always a student, Wolfsohn had many scientific papers to his credit. He belonged to the special societies concerned with his subject and, as we said above, was well known abroad, particularly in England where he had many close friends.

Outside of medicine, Julian's interests were no less varied. While in college he played tennis, and chess for the university team. He was a good pianist and an enthusiastic patron of music in all forms. His collection of United States postage stamps was of a sort to make even the advanced collector green with envy. Books were another hobby, and his library on neurology and psychiatry was outstanding.

His sudden death in the midst of active work is probably as Julian Wolfsohn would have wished it, but he can be badly spared, especially at a time when his colleagues and his country need him so keenly.

Arthur L. Bloomfield.

Henry C. Petersen

1875–1943

Dr. Henry C. Petersen, Sr., a member of the San Joaquin County Medical Society since 1907, passed away at his home in Stockton on Monday morning, May 17. He had suffered a hemiplegia last summer and had been confined to his house since that date. He seemed to be gaining in strength, and was hopeful of again resuming his professional responsibilities, when a sudden heart attack brought about his death.

Doctor Petersen was born on August 16, 1875, near Petaluma, California, and received his early education in the public schools of this State, mostly in San Joaquin County, to which area his parents moved when he was a child. He was graduated from the College of Medicine at the University of Illinois in 1905; and after a period of internship, he came to Stockton to practice. He was married in 1906 to Miss Cora Comfort; and in 1910, while he was traveling in London, England, where he was taking postgraduate work, a son, Henry C. Petersen, Jr., was born.

It was the Doctor's greatest happiness and pleasure to see this son follow in his footsteps: to graduate in medicine and join him in practice before his retirement last summer. Dr. Henry, Jr., also a member of this society, is now a lieutenant in the Army Medical Corps, temporarily stationed at Camp Barkeley, in Texas. Doctor Petersen specialized in obstetrics and enjoyed the confidence of a great many families in this area, where he had delivered several thousand babies.

In addition to his professional activities, he was always keenly interested in civic affairs and served for a number of years on the Board of Education, a portion of that time as its president. He was also always closely identified with church activities of this city, and was devoutly and sincerely interested in religious work. On many occasions he would ask his pastor to join with him in prayer when he was worried over a serious case, as he had great confidence in the help and in the power of prayer. In the passing of Doctor Petersen we have lost a well-trained obstetrician, a fine citizen, and a God-fearing and kindly Christian gentleman.

Dewey Powell, M. D.

He liveth long who liveth well!
All other life is short and vain;
He liveth longest who can tell
Of living most for heavenly gain.

—Horatius Bonar,
He Liveth Long Who Liveth Well.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION[†]

MRS. CHARLES C. LANDIS..................President
MRS. ROGER McKENZIE..................Chairman of Publicity

Woman's Auxiliary to the American Medical Association

Notes from the Twenty-First Annual Convention: Chicago, June 7, 1943

Report of Mrs. C. C. Landis, President of Woman's Auxiliary to the California Medical Association

Dear Auxiliary Members:

This year the Woman's Auxiliary to the American Medical Association attained its majority, and the annual meeting which was held at the Drake Hotel in Chicago, June 7 to 9, was one of seriousness and intensity of purpose befitting an organization which has so ably proved its worth all through its young and adolescent years.

Chicago, with its brightly lighted streets and blazing neon signs, is quite a contrast to our California coast cities. The Government has taken over several of the larger hotels, which makes the hotel situation rather difficult.

The Drake Hotel is a very interesting place, with ample accommodations for committee rooms and general sessions.

The American Medical Association held its House of Delegates meeting at the Palmer House.

The women of Chicago, under the very capable leadership of Mrs. Rollo K. Packard, former National President, had the arrangements well in hand.

On Sunday, June 6, the local registration committee were at their desks and many of the women took advantage of the opportunity to register early.

Monday morning, at nine o'clock, Mrs. Frank N. Haggard, National President, called the first meeting of the Board of Directors. The Treasurer announced that we have a paid-up membership of 25,127 in the Auxiliary to the American Medical Association, and that the finances of the organization are in very good condition.

This meeting adjourned just in time for us to get to the luncheon in the Gold Coast Room, which was in honor of the past presidents, seven of whom were in attendance. The speaker was Dr. Frank P. Hammond, Chairman of the Advisory Committee of the Woman's Auxiliary to the Illinois State Medical Society. His subject was announced as "Doctors' Wives—Medicine's Strongest Ally." He enumerated some of the objections he had met about forming an auxiliary and answered them very well. He believes that a doctor who senses the advantages and benefits of having an auxiliary to every county medical society should be chosen to contact each society where there is no auxiliary and sell the idea to them.

Mayor Frank Kelly welcomed us to Chicago, and told us of the Service Men's Clubs, where they care for 150,000 to 200,000 men and women of the services each week-end. Everything is free for those in uniform, even to pressing and mending their clothes when needed.

After the luncheon we went immediately to the Grand Ballroom for the formal opening of the convention.

We stood a moment in silence as a tribute to our deceased members, then Mrs. A. B. Pumphrey, President of the Texas Auxiliary, read the names by states.

Mrs. Haggard gave a fine report of the accomplishments of the organization during her year as president; but as this will be in the Bulletin, I shall not take your time by repeating. The other officers and the directors reported at this meeting, and these reports also will be published.

One thing that interested me was the membership report, which showed that California stood fourth in line. Pennsylvania ranked first with 2,785, Texas second with 2,210, New York third with 1,961, and California fourth with 1,858. Perhaps if we work just a little harder for those missing members, and try to keep the membership of those who are temporarily away, we shall be able to make a better record.

The busy convention day was completed by a very lovely tea in honor of Mrs. Haggard and Mrs. Eben J. Carey, President-Elect, given by the women of the Chicago Auxiliary and the Illinois State Auxiliary.

The second morning was taken up with reports from chairmen of standing committees. Seven of the ten chairmen were present and gave inspiring reports of the year's accomplishments.

The Tuesday luncheon was in honor of Mrs. Frank Haggard, the retiring president, and we were complimented by the presence of the following officers of the American Medical Association: Brigadier-General Fred Rankin, President; Dr. James E. Paullin, President-Elect; Dr. Morris Fishbein, Editor of *The Journal*; Dr. W. W. Bauer, Director of Public Health; and Dr. Frank Haggard and Dr. Eben J. Carey. All but Doctor Haggard gave addresses.

State presidents gave their reports in the afternoon session and were allowed five minutes each. Each one contained many helpful suggestions as to projects and policies.

Mrs. David Thomas of Pennsylvania is president-elect. California was honored by having our Mrs. Lindemulder elected as third vice-president.

In her inaugural address, Mrs. Carey outlined the objectives on which she wishes to concentrate this coming year. Briefly, they are as follows: social hygiene—elimination of venereal disease, especially around the Army camps; health education—a strong county health program; an alert Public Relations Committee; promotion of *Hygeia* circulation; Legislative Study Clubs; and keeping contact with members who are following their husbands in the service. She particularly urges the members to be leaders in all health activities in their communities.

In the evening we were invited to the opening meeting of the House of Delegates of the American Medical Association in the Grand Ballroom of the Palmer House. Brigadier-General Fred W. Rankin, M. C., U. S. A., presided, and introduced Dr. James E. Paullin of Atlanta Georgia, who was installed as president. In his inaugural address, he stressed the need for definite postwar planning for medicine, and felt we should coöperate with every organization striving to supply the needs of a war-torn world.

Mrs. Carey presided at the post-convention Board meeting on Wednesday morning.

The matter of national membership cards, which was brought to the convention by the Resolutions Committee and referred to the incoming board for consideration, came up at this meeting and it was voted to have the cards. Their information and method of distribution to be handled by a committee appointed by the President.

Dr. J. P. Simonds, of the faculty of Northwestern University Medical School, spoke of the "Effect of War on Medicine."

Mrs. Edward H. Greene, President of the Fulton County Woman's Auxiliary to Georgia Medical Society, presented the Doctors' Aide Corps as one of the newest defense organizations, Atlanta's being the first of its kind in America. It was formed as the result of an earnest desire on the part of the founders to make a very definite contribution to the war effort, and to do the work through the Auxiliary and not lose their identity as doctors' wives in other organizations. They have five services as follows: Information and Speakers' Bureau, Health Education and Health Films, Coöperative Service (such as Red Cross, Civilian Defense, A. W. V. S., etc.), Doctors' Emergency Service (such as working in a doctor's office as nurse or receptionist in an emergency), and the Blood Type Registry. The members of the Corps take a basic training of fourteen lectures on general health subjects, and then, after choosing the service they feel best fitted for, they take two weeks' training in this specialized line.

[†] Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Roger McKenzie, 138 Twenty-fifth Avenue, San Francisco. For roster of state and county officers, see page 6 in front advertising section.

The uniform adopted is a two-piece coat suit of navy blue gabardine with brass buttons, plain white blouse, black shoes, beige hose, blue felt cap, and top coat of the same material as the suit. The summer uniform is a shirtwaist dress of navy sheer with white collar. The insignia on the sleeve is the caduceus superimposed on their state seal, with "Doctors' Aides Corps, Atlanta Division" added.

The technical assistants must be well trained and work under a pathologist or doctor, and the whole program is under the Advisory Council of the Medical Society.

The Executive Board approved the plan and recommended it to the State Auxiliaries to promote locally. It is a method of keeping the identity of the Auxiliary in all of our war activities and deserves our earnest consideration.

The Doctors' Aide Corps, as well as other war activities, were placed under a new War Participation Committee, which will be a standing committee for the duration. The President will appoint the chairman and members. The American Medical Association has a new committee of the same name.

Final report of the Registration Committee showed 197 had registered for the meeting. It was gratifying to know that twenty-five state presidents, seven of the chairmen of standing committees, and four directors made personal reports.

It was a privilege to attend the meeting of the National Board and meet our leaders, and I trust that I may be able to pass on to you some of the inspiration gained. Thank you for making this experience possible.

Mrs. C. C. Landis,
President, Woman's Auxiliary to the California Medical Association.

CALIFORNIA PHYSICIANS' SERVICE[†]

Beneficiary Membership

Commercial (July, 1943)		48,810
Rural Health Program		5,000
War Housing Projects (approximate)		39,535
Marin	6,304	
Los Angeles	6,391	
San Diego	12,000	
Vallejo	10,952	
San Francisco	3,888	
Total		93,345

Under date of July 30, the following letter was sent to the secretaries of county medical societies in those counties where California Physicians' Service has been rendering medical care to residents of war housing projects, with the exception of San Diego.

* * *

The Members of the County Societies, Addressed.

I am enclosing copy of a letter which was recently sent to all housing authorities with which California Physicians' Service has entered into contracts to render service in the Federal Housing Projects.

You are undoubtedly aware that the California Physicians' Service program is inadequately financed, to the point where we cannot continue to ask local physicians to accept the insufficient fees for services that we are able to pay. This notice follows out of a sequence of meetings with the Coördinating Committee of the Procurement and Assignment Service of the War Manpower Commission, which adopted the following resolution:

> It is the considered opinion of this Committee that the present method of furnishing medical care to residents of housing areas, through California Physicians' Service, is the most desirable method known to the Committee under present circumstances, and we recommend that the Federal Public Housing Authority be urged to take all steps necessary, within its authority, to obtain the necessary funds to insure that this program shall be continued.

The second meeting was with all of the housing authorities concerned, which adopted a resolution which we quote, in part:

> 1. It is essential that medical care be made available to residents of War Housing Projects.
>
> 2. It is agreed that California Physicians' Service is the only medium through which such service can be made available in these critical war areas.

A third meeting was held with all of the governmental agencies concerned with war production, together with the United States Public Health Service, State Department of Public Health, and the California Medical Association. A resolution was adopted by this group as follows:

> Resolved, That the Federal Public Housing Authority be requested to recognize the great need for medical care in housing projects in communities that cannot be provided for by any other means, and that the FPHA be requested to authorize local housing authorities to enter into such contracts with California Physicians' Service as may be necessary and desirable for insuring the continuation and extension of the California Physicians' Service program.

We hope to get speedy action on this combined public sentiment. It will be necessary that this matter be taken to Washington for final decision. We shall keep you informed from time to time of subsequent developments.

In the meantime, we should like to urge upon participating physicians the necessity of continuing to discharge our contractual responsibility. It is to be remembered that the financial position of the housing projects in no way affects the regular California Physicians' Service program for commercial groups.

A. E. Larsen, M. D.,
Executive Medical Director.

* * *

Representatives of the Federal Public Housing Authority and the California Physicians' Service will go to Washington with specific information as to the proposed new plans for the consideration of Mr. Herbert Emmerich, Commissioner of the Federal Public Housing Authority.

During the past month there has been a great deal of discussion about the California Physicians' Service plan for war workers, and it is apparent that all parties concerned are very anxious that some medical care program should go forward and be extended to other critical areas. The situation in the State has not settled down and, as a matter of fact, it is becoming increasingly severe. The interest of the population concerned has been aroused, and it has become a matter of deep consideration with the public health officials. It is to be remembered that at the present time the incidence of illness is at its seasonal low. In the year 1942 we had several phases of disease in near-epidemic proportions. It is the prediction of those concerned with public health that the virulence of disease during the coming winter months may be expected to be considerably stronger than last year.

[†] Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

The doctors in the immediate area have continued to support California Physicians' Service during its negative period in all areas except San Diego, where California Physicians' Service has had to withdraw because of the lack of physician support.

Letter from Council Chairman Gilman to San Diego County Medical Society re Medical Service in Housing Areas

(COPY)

W. H. Geistweit, Jr., M. D., Secretary,
San Diego County Medical Society,
233 A Street.
San Diego, 1, California.

Dear Doctor Geistweit:

Doctor Kress has shown me your letter of July 27 concerning the California Physicians' Service situation in the federal housing areas, and I am happy to enclose for your information and that of your members a letter which is being sent today to all county medical societies.

For your further information, the meeting held earlier this week brought together all the parties, both private and Governmental, who are concerned in the furnishing of medical care to the residents of the federal housing areas. No punches were pulled in this meeting. The issue was stated squarely by California Physicians' Service, namely, that without proper and adequate financing the housing area projects must be dropped by California Physicians' Service. All those present, including the managers of the various housing areas, agreed that adequate financing must be arranged, and all recognized that the physicians could no longer be asked to carry the financial load of the program. A copy of the resolution adopted at this meeting is enclosed.

As a result of this meeting, it is apparent that by the end of September we will either have a solution of this problem or California Physicians' Service will withdraw from all housing areas.

To return to your specific question, regarding the action of the California Medical Association Council on the requests made by your delegation to our Council meeting, the Council voted to request the housing authorities to adopt a more liberal policy of permitting private practitioners to render medical care to housing area residents who are not covered by California Physicians' Service. The housing authority representatives appeared most agreeable to this suggestion and I believe this matter can be worked out to the satisfaction of all physicians concerned.

However, the information in the paragraph above has more recently been dwarfed by the decision of California Physicians' Service to withdraw from all housing areas in San Diego County on August first. This withdrawal is going to put upon the private physicians of San Diego County the responsibility of meeting completely the medical care requirements of the residents of housing areas in the county.

I am informed that California Physicians' Service has been handling an average of more than 2,000 office visits and more than 300 home calls a month in the housing areas in San Diego County. This large volume of work will immediately be dropped into the laps of the private physicians of San Diego County, and I believe it is wise to caution you and your fellow members at this time that a grave responsibility has been given to you. None of us knows exactly what alternatives the housing authorities may resort to if adequate medical care is not given to this large group of people, but it must be evident to us all that the medical profession must handle this number of patients in an adequate and satisfactory manner in order to preserve the reputation of the private practice of medicine.

In review, the two things asked by your delegation of the 1943 House of Delegates as alternatives have now both been accomplished. First, steps have been taken to allow private practitioners to practice in the housing areas, and, second, California Physicians' Service has withdrawn from San Diego County. I am sure there is no feeling of vindictiveness on the part of anyone, and I sincerely hope that the physicians in San Diego County will be able to handle the housing area patients of the county without more than a minor interruption in the service these people require and have been receiving through California Physicians' Service.

At the same time, I would like to call your particular attention to the fact that the regular California Physicians' Service program is continuing the upward swing started some months ago and is today in the best financial position in its history of almost four years. I trust that there will be no confusion between the regular program and the housing area program in the minds of your members and that the California Physicians' Service professional members of San Diego County will continue their demonstrated support of the regular program.

Cordially yours,

PHILIP K. GILMAN, M. D.,
Chairman of the Council.

July 30, 1943.

City Baby Spree Dooms M. D. Service

The stork may have killed the medical care program of Vallejo Housing Projects.

Because, among other factors, there were 100 births per 1,000 population in the housing projects since last December, compared with the national average of 17-plus per 1,000 persons, the California Physicians' Service (CPS) has found that income from the medical care program will not meet the costs.

Ends Next Month

So, unless plans to save the program go through, it will end on September 30. CPS has served notice on the Vallejo Housing Authority that it wishes to be absolved of responsibility under its contract to provide medical care for the Vallejo Housing Authority tenants, unless new provisions for higher payments can be made. (A new contract has been submitted and is under consideration.)

These provisions call for more money for local doctors who are participating in the program.

Originally set up to provide the physicians with returns for treatments of patients of roughly $2.50 an office visit, the returns have dropped to 50 cents or less per visit.

$100,000 in Fees

Briefly, the program is set up this way:

Tenants participating in the program pay a medical insurance premium of $2.50 monthly for a single man, $4 for a couple, and $5 for a family of three or more.

To date, these fees have totaled $100,000 or more for medical care. The fees are collected by the Housing Authority and turned over to the California Physicians' Service, which administers the entire program.

CPS has staffed the various projects with physicians whose full-time duties are to care for persons under the medical care program. CPS also has assigned approximately fifteen nurses to the various projects.

15 Per Cent to CPS

The money collected and turned out to the CPS is divided roughly in this manner:

Fifteen per cent goes to the CPS for administrative costs.

Of the rest, the cost of staff physicians and nurses, offices and supplies is provided, as also are costs of hospitalization and laboratory fees.

The remainder is left for the Vallejo physicians who are participating.

They are not paid a cash value for each treatment, but rather by unit. The unit charge is a definite one, that is, for example, two units for the first visit and examination, one unit for subsequent office calls, and specified units for each type of specialist work or operation.

Paid Each Month

When the month is ended, each of the seventeen participating Vallejo and outside physicians send in a "bill" for the total units they have charged for treatment and these are divided into the money left.

At the inception of the program this unit, therefore, was $2.50, but as time has gone on and additional cases were referred to the doctors by staff physicians (the only time a patient goes to a local doctor is on referral) the number of units has climbed much more sharply than the income.

The result is that unit values have dropped to approximately 50 cents at the last available figures, setting 50 cents as the return on an office call and $12.50 as the actual return on a $50 operation.

Local Doctors Lose

The last figures coming to the writer's hand showed that the patients under the program actually were paying only 71.7 per cent of the total cost of medical care and the entire 28.9 per cent that is short is taken from the fees of local physicians.

Three possible solutions are offered to salvage the program:

1. Contribution to its operation by a local or the Federal Government, probably the latter.
2. An increase in charges to those tenants participating.
3. A reduction in services.

United States May Help

In the case of Point 1, an effort to see what federal aid may be forthcoming will be made in about ten days when Langdon Post FWA director for this area and Dd. A. E. Larsen, president of the CPS, go to Washington to confer with various officials.

There are definite arguments against taking either the second or third step.

In the first place, the success of the program as designed and introduced by CPS depends upon 90 per cent participation by tenants. This goal has been achieved, but actually the program would be much more successful from a business standpoint if there was 100 per cent participation. This is because there is that percentage of the population which practically never needs medical attention and their contribution to the program provides the surplus to make it effective.

Many Might Quit

On this same line, the CPS program calls for more medical attention for families because it provides for virtually every contingency, including obstetrical treatment.

Therefore, if the cost were raised many people might withdraw and the majority would be those who seldom need treatment and are carrying the burden without reaping benefits. By the same token, if care were limited, the withdrawals would have the same effect.

So it is questionable whether any but the first of the above tabulated methods would actually save the program.

Many are the reasons given why the program as first set up by CPS was not economically sound. Among primary causes is the birth rate. Nationally there are 17-plus births per 1,000 population. In housing projects in the United States before the war the average was 22-plus per 1,000. To be "safe," CPS figured its medical costs on a birth rate in the Vallejo projects of 25 per 1,000.

100 Babies Per M

Instead, the birth rate has been 100 per 1,000.

Also, doctors feel, there are many people who have needed some medical attention for years, but have postponed treatment, usually for financial reasons. Under the program they have taken advantage of the cheap rate and have had long-pending ailments treated.

Theoretically, after a period of time, the health of all those participating in the program should be raised to the point where treatments would be at a minimum and the local physicians would receive adequate return for their efforts.

Let it be understood that Vallejo is not the only place where CPS has found it economically unsound to operate. The condition prevails in the entire state. According to CPS compiled figures for the period of eight months, of which Vallejo participated only five, the cost of the program for the entire state was $259,094, while the income received from tenants was $185,755. Vallejo's figures for the period are $87,611 cost and $62,838 income. (As noted above, this income actually now is above $100,000, but the costs are correspondingly higher.)

A breakdown of the CPS figures also shows that the costs of the medical centers here is 3.1 per cent less than the state, hospitalization costs are five per cent higher, administrative 1.1 per cent higher.

Socialization Dodged

There were many factors behind the type of service set up by CPS here, but primary among them was the thought of physicians that the medical care was the doctor's reply to the profession's self-announced bugaboo—socialized medicine.

So, in the event of the final failure of the program by physicians, it seems likely that those groups which advocate socialized medicine will hop aboard the band wagon with glee and announce the following stand:

"The physicians have tried their plan and have failed. Now give us the same opportunity to experiment ten months with socialized medicine as we want to do it."

So it is entirely possible that the housing projects may provide the final answer to whether all persons may have adequate and complete medical care at the cost of an "insurance premium."—Vallejo *Times-Herald*, August 15.

Residents to Have New Medical Care as CPS Is Discontinued

Due to the fact that membership in the California Physicians' Service plan showed a decline from 63 per cent of the residents in January to 48 per cent in June, the CPS was discontinued as of July 31. Reasons listed for the discontinuance were insufficient finances, and the fact that maternity cases in the Federal Housing areas have been approximately four times the average birth rate of the United States as a whole.

Every effort is being made by management to insure adequate medical care for Linda Vistans, and three physicians are already installed in the medical center. Present plans are for one physician for every thousand residents, and doctors qualified to practice in San Diego, or migrant physicians approved by the California Medical Association will be considered. Other applications are now pending.—San Diego, *Aircraft Mechanic*, August 6.

"We Want CPS," Housing Tenants Say

The threatened dissolution of the California Physicians' Service health insurance program in the Federal Housing Projects, where it now operates, this week brought pleas for its continuance from organized tenant groups.

At Richmond's Harbor Gate project, representatives of nine housing projects in the Bay area met to organize the nation's first interhousing project tenants' council and passed a resolution asking Federal Housing Authority executives to save the health plan.

CPS has notified the housing projects that it cannot continue furnishing doctor and nurses unless a new financial arrangement is devised.

The new council, made up of democratically elected delegates from nine Bay area housing projects, named David Landy of Harbor Gate as its temporary chairman.

At Marin City the community council passed a concurring resolution which states that "Marin City would find itself in a most alarming situation if no medical service is arranged for us." The resolution commended the work being done by CPS in the project and revealed a serious shortage of doctors in near-by communities.

CPS has informed projects it will suspend service on September 30. A delegation of officials, including Dr. Edwin Larsen, State CPS director; Judge Guy at Ciocca, executive director at Marin City; and William G. Reidy, regional FPHA project services director, left for Washington this week to work out a new health insurance arrangement that would be agreeable with national FPHA authorities.—San Francisco *Chronicle*, August 26.

Farm Security Repayments Pass New Loans

Ralph B. Randall, Farm Security supervisor for Riverside and San Bernardino counties, disclosed yesterday that FSA farmers here had repaid the agency more than twice the amount of money they borrowed during the fiscal year ending June 30.

Health Program Organized

The rural health medical program for all "small farmers" and their families was organized this year with the assistance of FSA field personnel. The advantages of this group medical and hospital service were made available through California Physicians' Service and the Hospital Service of Southern California. The members of the Bi-County Farmers' Health Association plan to expand the program this coming year. . . . Riverside *Enterprise*, August 4.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings[†]

California Medical Association. The seventy-third annual session will be held in San Francisco. A two-day session (Sunday and Monday). Date will be announced later.

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American Medical Association. Place and date of 1944 annual session to be announced later.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts[*]

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a. m., under the title "Your Doctor and You."

In September, KFAC will present these broadcasts on the following Saturdays: September 4, 11, 18, and 25.

The Saturday broadcasts of KECA are given at 10:45 a. m., under the title "The Road of Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association, in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy, are on the air each Saturday at 2 p. m., Pacific War Time.

Pharmacological Items of Potential Interest to Clinicians[*]:

1. *Texas Reports on Biology and Medicine:* Second issue, with articles on spotted fever, vasomotor factors in the etiology of hypertension, and vitamins on adaptation to low pressure, may be a wee bit delayed. Tropical disturbances of moderate intensity do peculiar things. Third issue coming up has articles on war surgery, neurosyphilis, and rickettsial diseases. May there be no more hurricanes here for a spell!

2. *For the historically minded:* Random House, New York, issues G. Myers' *History of Bigotry in the United States*, a timely study in nasty psychology. P. B. Hoeber, New York, publishes A. E. Truby's pleasant *Memoir of Walter Reed: The Yellow Fever Episode.* A beautifully illustrated series of articles on Vesalius by Castiglioni, Francis, and Fisch, gets notice in *Time* (*Bull. Med. Lib. Assn.*, 31:201-259, July, 1943).

3. *Books, Books, Books:* It's time to parody Kipling! W. B. Doherty & D. D. Runes' *Rehabilitation of the War Injured* (Philosophical Library, New York—sic!) looks like the same outfit's *War Medicine*—a bound collection of recent reprints. W. D. Forbus writes a new style pathology: *Reaction to Injury*, issued by Williams & Wilkins. Baltimore. A. E. Wright discusses the *Pathology and Treatment of War Wounds* (William Heineman, London). Same publisher issues D. Harley's *Blood Group Determination.* Academic Press, New York, offers first volume of R. S. Harris and K. V. Thimann's *Vitamins and Hormones.* S. Wolf and H. G. Wolff (yes) long study *Human Gastric Function* in the style of William Beaumont (Oxford Press, New York). Grune & Stratton, New York, offer a $12 book by E. Urbach on *Allergy.* The Commonwealth Fund, New York, issues a neat brochure by G. N. Papanicolaou and H. F. Traut on *Diagnosis of Uterine Cancer by the Vaginal Smear.* Volume 6, Annals American Academy of Political and Social Sciences is on *Nutrition and Food Supply: The War and After.*

4. *Hot Session Faraday Society:* Important discussion on modes of drug action is announced by Faraday Society for Friday, September 24, 1943, at the Hotel Rembrandt, South Kensington, London, SW 7, with H. H. Dale and J. H. Gaddum opening the morning meeting with Quastel and McIlwain on biological aspects, and E. K. Rideal opening the afternoon meeting on physical chemical aspects, with King, Schulman and Scott. Send a note.

5. *Here's to Edwards Bros. lithoprinting:* Alien Property Custodian releases lithoprinted German scientific periodicals from Edwards Bros., Ann Arbor, with flashy orange covers. H. Lettre and H. Fernholz report on relation between toxic mitosis effects and constitution of colchicine derivatives, showing significance of sympathicomimetic group (*Hoppe-Seyler's Ztschr. Physiol. Chem.*, 278:175, 1943). H. Albers & Co. give much data on hemolytic action of acids and bases (*Biochem. Ztschr.*, 314:186, 1943).

6. *Etc.:* H. Henry and M. Stacey (Birmingham) study histochemistry of Gram staining and suggest Gram-positive (dye-retaining) material is high molecular complex of a reduced basic protein substrate with magnesium ribonu-

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[†] In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

[*] County societies giving medical broadcasts are requested to send information as soon as arranged.

[*] These items submitted by Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

cleate (*Nature*, 151:671, June 12, 1943). J. Boyes-Watson and M. F. Perntz find by x-ray analysis of hemoglobin that the molecule is a rigid four-layered platelet 36 by 64 by 48 A° in size (*ibid.*, June 26, p. 714). K. Bailey & Co. show same peculiar shape of molecule common to keratin, myosin, fibrinogin and fibrin, and suggest biochemical adaptive evolution (*ibid.*, p. 716). F. Sjostrand (Stockholm) describes technique for electron microscopic examination of tissues (*ibid.*, p. 725). G. S. Carter & Co., (*ibid.*, p. 728) find paraxanthine is normal antithyroid, and metabolism is low if concentration is balanced with thyroid, and high if either is in excess. O. A. Trowell (*ibid.*, p. 730) reports that anoxemia causes liver vacuoles. K. Meyer et al. (New York) by-pass rapid excretion of penicillin in noting effectiveness of slow hydrolyzing ethyl and butyl esters (*Proc. Soc. Exp. Biol. Med.*, 53:100, 1943). S. Rothman and P. Flesch (*ibid.*, p. 134) isolate red iron pigment from human red heads—no wonder they're tough! T. Gillman (*S. Afr. J. Med. Sci.*, 8, 50, 1943) recommends excretion of neutral red by gastric mucosa (max. conc. 6 to 20 minutes after fourth injection 5 c.c. 1 per cent sol.) as a valuable test of gastric function.

Doctors of Medicine as Others See Them.—"During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest."

The above item, with some quotations, appeared in CALIFORNIA AND WESTERN MEDICINE: July, 1942, issue, pp. 108-109; October, pp. 269-270; November, pp. 287 and 331-332; January, 1943, issue, pp. 49 and 50; February, pp. 92-93; April, pp. 255-257; May, pp. 305-308; July, p. 96; and August, pp. 146-147. More recent items follow:

WHILE OTHERS CHEER

When the prospect of peace becomes more real, literally hundreds of millions of people will stand ready to join in a deafening tumult of relief and happiness. Victor and vanquished alike will revel in a reunion with loved ones.

But there is one group whose shouting will be muted—the doctors. For them the job of rebuilding the shattered wreck that humanity has made of itself and of the world, will begin. Many of them will not be able to return home. They will have to stay in faraway places battling as they never battled during the war, against disease and starvation. They will have to work against time to develop new aids and new techniques in a world-wide struggle to control the spread of fearsome maladies. These men in white know that the war has created medical problems which, if not solved, could easily make the war itself look like a pink tea. No, the doctors will not cry out in carefree happiness when this war ends.

Laymen, who know so little of the grim task the doctors face, should endeavor to ease their burden wherever possible. The standards of our medical men are high. They serve rich and poor alike to the best of their ability, and the ability of American doctors is not surpassed. We should reflect soberly on these things in the years ahead when the doctors will be fighting the greatest battle of all time—for us—and pause before heeding an insatiable howl for an impossible medical Utopia under the banner of social reform.—*Ceres Courier*, July 30.

* * *

PRESERVING HEALTH OF NATION

With more than a third of the nation's doctors in the armed services and 10,000 more to be called this year, the 130,000 physicians still in civilian life are doing all they can to preserve the nation's health. That their efforts are availing is indicated by the fact that there are no widespread epidemics.

But public health officials, aware that there is only one effective physician to every 1,500 persons, fear the long-term effect of lack of adequate medical attention. Conditions scarcely evident now, it is feared, may develop into serious diseases for many persons. Many physicians now are specialists whereas the need is for all-purpose doctors. Others are too old for intensive work.

There are only 70,000 nurses in training and 107,000 additional nurses are needed. Between now and next July an estimated 79,000 nurses will be called by the armed services and a total of 293,000 will be needed by the civilian population.

There were 447,674 beds in general hospitals in 1941 and 166,254 more are needed now. In mental hospitals there are 641,770 beds, with 193,398 more needed, and in tuberculosis hospitals there are 89,945 beds and 54,459 more are needed. —*Napa Register*, August 17.

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GREAT DEMAND ON DOCTORS

Our armed forces want six thousand additional physicians by January first, it is announced in Washington. Ten thousand more nurses are also needed at once. Generals in command of various units have been authorized to induct physicians between the ages of 38 and 45 who have been declared available by the directing board of the procurement and assignment service for physicians.

If not enough doctors respond to the call, it is predicted that regulations will be made to draft them. It is possible that older physicians may be taken into the military service as needs may demand.

This information should be received seriously by all American civilians. It means that many who have the habit of running to the family physician for all kinds of minor ills will need to solve some of their own health problems, or at least make their demands upon the time of the doctor less frequent.

It is time for the American public to start thinking more about healthful living. It is not suggested that the people take up any queer health fads or start dosing themselves for real or fancied ailments. But there are many sound, common-sense health habits that can be adopted and pursued by the average citizen to his personal benefit and the relief of the hard-pressed medical profession.—Santa Rosa *Press Democrat*, August 8.

Symposia: Auspices of California Heart Association.—The California Heart Association is proud to announce that Dr. Tinsley R. Harrison, Professor of Medicine at the Bowman Gray School of Medicine, Winston-Salem, North Carolina, will be the guest speaker at the symposia to be held this fall in San Francisco, Los Angeles and San Diego. Among Doctor Harrison's topics will be "The Abuse of Rest in the Treatment of Cardiovascular Disease," "Gastrointestinal Disorders Simulating Angina Pectoris," "Some Conditions Commonly Confused with Coronary Thrombosis," and "Some Common Errors in the Interpretation of Electrocardiograms as Indicating Coronary Artery Disease." A clinical pathological conference will be arranged.

Dates for the symposia are: San Francisco, Thursday, Friday and Saturday, November 4, 5 and 6; Los Angeles, Thursday and Friday, November 11 and 12, and for the dinner meeting in San Diego, the evening of Tuesday, November 9.

Physicians interested in registering for these meetings will write to Dr. David A. Rytand, program chairman, San Francisco Heart Committee, 604 Mission Street, San

Francisco 5; and Dr. William Paul Thompson, program chairman, Los Angeles Heart Association, 122 East Seventh Street, Los Angeles 14. The San Diego meeting will be held under the auspices of the San Diego County Medical Society.

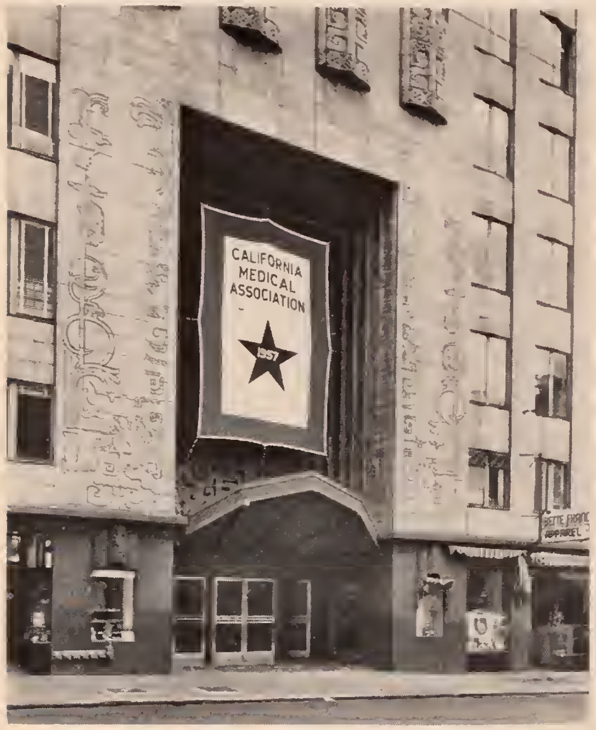

Fig. 1.—Service flag of California Medical Association.

The above is a photo-illustration of the entrance to the Four Fifty Sutter Building in San Francisco where the C. M. A. headquarters offices are located. At the time the flag was placed in position in August, 1943, a total of 1,957 members of the California Medical Association were serving as officers in the medical corps of the Army and Navy.

Caltech Shares in $7,000,000 Eagle Estate; Bequest for Medical Research.—Bequeathing the bulk of an estate valued at more than $7,000,000 to the California Institute of Technology, the will of John H. Eagle, retired Pennsylvania silk manufacturer and big game hunter, was filed for probate yesterday in Superior Court. . . . The document then provides that four-fifths of the remainder of the estate go to the California Institute of Technology for the promotion of research in the prevention and cure of disease. In addition the will specifies that this fund, to be known as the John H. Eagle Endowment, be used to award prizes for distinguished service to humanity in the fields of chemistry, physics, medicine and other scientific endeavors.—Los Angeles *Times*, August 13.

Stanford University Receives Allocation for Tropical Medicine.—For the six months' period ending June 30, 1943, twelve grants amounting to $43,680 were made by the American Foundation for Tropical Medicine, Inc., 350 Henry Street, Brooklyn, N. Y., to eleven North American medical schools, a scientific journal and the Army Medical Museum.

Among medical schools to receive grants during the period from April 1 to June 30 was the Stanford University Medical School, the allocation being listed as follows: "Stanford University Medical School: Salary for full-time technician and funds to purchase supplies and equipment to strengthen teaching of tropical medicine."

American-Soviet Medical Society President Cannon Honored by Russian Academy of Sciences.—Dr. Walter B. Cannon, president of the American-Soviet Medical Society, will be formally inducted as a member of the Academy of Sciences of the U. S. S. R. at a reception given in his honor by the Soviet Embassy on Thursday, August 12. Doctor Cannon, who is Professor Emeritus of Physiology at Harvard, is the first American to be a member of both the Academy of Sciences of the United States and that of the U. S. S. R. . . .

The American-Soviet Medical Society which Doctor Cannon now heads has been organized to stimulate the exchange of medical information between this country and the Soviet Union. Doctor Cannon has done much to encourage this exchange. A paper he delivered several years ago before the International Congress of Physiologists in Moscow met with great acclaim.

The national headquarters of the society are at 130 West Forty-sixth Street in New York City. The *American Review of Soviet Medicine*, its publication, maintains editorial offices at 1900 East Monument Street in Baltimore.

Two other American scientists, Dr. Ernest O. Lawrence, Professor of Physics, and Dr. Gilbert N. Lewis, Professor of Chemistry, both at the University of California, are being similarly honored.

American Congress of Physical Therapy.—This congress will hold its twenty-second annual scientific and clinical session September 8, 9, 10 and 11, 1943, inclusive, at the Palmer House, Chicago. Rehabilitation is in the spotlight today, and physical therapy plays an important part in this work. The annual instruction course will be held from 8 to 10:30 a. m., and from 1 to 2 p. m. during the days of September 8, 9 and 10, and will include a round table discussion group from 9 to 10:30 a. m., Thursday, September 9. The scientific and clinical sessions will be given on the remaining portions of these days and evenings. A feature will be an hour demonstration showing technic from 5 to 6 p. m. during the days of September 8, 9 and 10. All of these sessions will be open to the members of the regular medical profession and their qualified aides. For information concerning the instruction course and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

Residency Vacancies in Los Angeles County Hospital.—The Los Angeles County Civil Service Commission announces unassembled examinations for the positions of resident physician in the specialties of general medicine; pediatrics; otorhinolaryngology; and orthopedic surgery.

These positions, paying $130 a month, are for work in the Los Angeles County General Hospital for periods of two and three years—subject to break-in service at the end of one year's residency for military duty by action of the Procurement and Assignment Service.

Requirements.— Age: At least 21 years and not over 55 years on the last day for filing. Education and training: Graduation with a degree of M. D. from an approved medical school and completion of at least a one-year internship in an approved hospital. Applications will be accepted from interns who are in their first year of internship at the time of filing. Pending completion of their one-year internship and presentation of proof thereof, the names of candidates will be withheld from certification for appointment. License: Candidates must possess, or be able to secure promptly a physician and surgeon's certificate to practice in California and must present such certificate before appointment is complete and if possible at the time of filing application.

Special Information.—There will be no written examination. Candidates will be rated on their professional training and experience and their aptitude and personal suitability as evidenced by investigation or interview. Candidates must submit with their applications the name of the medical school from which they were graduated and the place, types and durations of their internships and prior residences, and must also submit with their applications their unmounted photographs taken within two years and the names of two physicians qualified to evaluate their professional training and experience.

Quinine.—The safest and surest defense known against malaria is quinine, made from the bark of the cinchona tree. Ninety-five per cent of the world's supply formerly was produced in the Netherlands Indies.

Although some new anti-malaria drugs are on the market today—atabrine and plasmochin—malaria is increasing and estimates are that, in addition to the new drugs, the United Nations will require at least 10,000,000 ounces of quinine a year.

It takes about ten years to bring a cinchona tree to maximum bearing, although some bark can be obtained in from three to four years after planting. Several years ago, Philippine scientists developed a comparatively rough bark extract called "totaquine" (poor man's quinine) which can be made from the bark of wild trees.

High-yielding, cultivated cinchona trees are now being established in Latin America. Guatemala, with an estimated resource of 1,600,000 cinchona trees planted in 1878, is the pace-setter. Seeds from the Guatemala trees are being widely planted by the Colombian Government.

In March, 1943, Costa Rica signed an agreement with the United States to provide 10,000 acres to be planted to cinchona trees under the direction of the United States Department of Agriculture, the whole project to be turned back to Costa Rica in twenty-five years.

Our Department of Agriculture has recently sent high-yielding cinchona seedlings to Sao Paula, Brazil; and has assigned foresters to locate wild cinchonas in Colombia, Ecuador, Peru, Bolivia and other South American countries.—*Nation's Business*, August, 1943.

Psychiatric Residencies.—At St. Elizabeth's Hospital, the Federal institution for the treatment of mental disorders, Washington, D. C., fine opportunities for psychiatric residencies and rotating internships are open to recent graduates of medical schools; these residencies and internships rank among the best in the United States. The institution has 7,000 patients including members of our armed forces who are casualties of the present war. In order that these men as well as civilian patients receive adequate care and treatment, it is necessary to recruit a number of junior medical officers. For information, address: U. S. Civil Service Commission, Washington, D. C.

Quarantine Placed on Mussels.—Dr. Wilton L. Halverson, Director of Public Health and Executive Secretary of the State Board of Public Health, placed a quarantine on all mussels along the ocean shores of California, including the Bay of San Francisco, from the Oregon-California boundary line on the north to the California-Mexico boundary on the south.

All health officers and food inspectors were instructed to enforce the provisions of the quarantine and to prohibit the taking, sale or offering for sale of mussels in or from the area specified, with the exception that permission may be given to take mussels to be used for fish bait, if such mussels are rendered unfit for food purposes by processing with salt. It is stipulated further that the containers in which such processed mussels are placed must be labeled "For Fish Bait Only—Unfit for Human Consumption."

Health officers of the coastal and bay counties were instructed to place quarantine signs in conspicuous places, stating that mussels are unfit for human consumption if taken during the period May 1 to October 31 and that it is unlawful to take, sell or offer them for sale during that period. The quarantine signs warn the public that clams should be cleaned and washed thoroughly before cooking them and that all dark parts should be discarded because the poison when present during the May to October period would be concentrated in the dark tissues. Only the white meat should be prepared for cooking and eating.

These regulations are in addition to any permanent quarantines that may have been established on shell fish because of sewage pollution.

Association of Military Surgeons of the United States.—The Association of Military Surgeons of the United States will begin its three-day sessions in the Bellevue-Stratford Hotel in New York on October 2.

The symposium on war medicine will be of vital and direct interest to the health and welfare of the men in the armed forces, to physicians, research specialists and scientists everywhere, as well as to the general public. The Committee on Arrangements may be addressed at Room 603, 1520 Locust Street, Philadelphia, Pa.

Memorial Fund at Stanford to Late Dr. Julian M. Wolfsohn.—In tribute to Dr. Julian M. Wolfsohn, clinical professor of neuropsychiatry in the Stanford University School of Medicine, who died July 1, eighteen memorial gifts have been received by the University.

The fund will be reserved in the School of Medicine as a memorial to Doctor Wolfsohn, and will be used especially for neurology and psychiatry, Dean L. R. Chandler said.

Doctor Wolfsohn had been a professor at the medical school since 1913. He was a members of the psychiatric board at Alcatraz Penitentiary.

Contributors to the fund are Dr. Vender Leonard, Dr. and Mrs. William Schwartz, Mrs. E. D. Lederman, Mr. and Mrs. Lewis S. Rose, Samuel Meyer, Mr. and Mrs. Arnold Liebes, Mrs. Melville Marx, Lester Luz, Philip R. May, Dr. Robert Klingel, Dr. F. J. Halford, Dr. and Mrs. F. L. Reichert, Dr. J. B. McNaught, Alpha Kappa Kappa medical fraternity, Dr. L. W. Ketron, Mr. and Mrs. Sidney Loeb, Mr. and Mrs. Milton N. Salz, Dr. Frederick W. Kroll, Mr. and Mrs. M. P. Lilienthal, and Dr. Ferd W. Callison.

Ray Lyman Wilbur, M.D., Retires as President of Stanford University; Donald B. Tressider, M.D., Becomes President.—Dr. Ray Lyman Wilbur yesterday retired as president of Stanford University, an office he has held since 1916, and resumed the post of chancellor emeritus of the university.

Doctor Wilbur, one of the nation's most distinguished educators and a member of Stanford's first graduating class in 1896, was succeeded as Stanford's president yesterday by one of his former students—Dr. Donald B. Tressider, San Francisco physician.

Stanford's new chancellor emeritus was Secretary of the Interior in the Cabinet of President Hoover. He is former president of the American Medical Association.

Since reaching the retirement age of 64 in 1941, Doctor Wilbur has been serving as the university's acting president and chancellor. He announced yesterday that he plans to continue as president of the American Social Hygiene

Association and chairman of the American Medical Association's council on medical education and hospitals. He also is closely associated with the Institute of Pacific Relations.

The author of several collections of essays and medical works, Doctor Wilbur disclosed yesterday that he is at work on an autobiography.—San Francisco *Examiner*, September 2.

Poliomyelitis Takes Sudden Spurt in City.—A sudden jump in the number of poliomyelitis cases in Los Angeles was indicated in the weekly report yesterday of the Los Angeles Health Department, which listed twenty-seven new cases last week, bringing the total for the year to 150, compared with sixteen for the same period last year.

Approximately eleven new cases over the week-end was indicated in a report yesterday from the office of City Health Officer George M. Uhl, which listed the total up to yesterday noon as 161 cases for the year.

It was announced that the disease is above normal in Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, San Francisco, Santa Clara, Solano and Sonoma counties.

The disease is spread from person to person, according to a health department statement, but the method of the spread is not known. The following was advised:

"Parents should keep their children away from crowds and strangers and at home as much as possible. In areas where the disease is prevalent, operations on the nose and throat should be postponed. Children should not be allowed to become overtired. They should observe regular hours of sleep and rest and should receive plenty of nourishing, wholesome food."—Los Angeles *Times*, August 24.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Physicians Meet At Sonoma

Santa Rosa, July 29.—Medical men of Sonoma, Napa, Solano, and Marin counties will gather tonight in the clubhouse at the Sonoma golf links for a dinner and discussion of outstanding problems in connection with health emergencies. It is the annual get-together of the four medical groups. Officers of the State Medical Society are expected to attend, and representatives of the district in the State Legislature are invited guests.—Petaluma *Argus-Courier*, July 29.

Dr. Karl Schaupp Speaks At Northbay District Doctors' Gathering

By State Senator Herbert W. Slater

While it was hardly in the nature of a transposition from "log cabin to White House" in the way of advancement, it was, nevertheless, a very happy meeting on Thursday night at the big district gathering of medicos in the clubhouse at the Sonoma Valley golf course between Dr. Karl L. Schaupp, eminent San Francisco surgeon, president of the California State Medical Association, and myself.

It was Doctor Schaupp himself, when we exchanged greetings for the first time in goodness knows how long, who said:

"Don't you remember as a small boy I delivered *The Press-Democrat* in Santa Rosa? That was a long time ago and when Jim Ramage was the circulation manager. I made more money than the other newsies because I drove a pony and cart in delivering my route early in the morning," Doctor Schaupp smiled.

Of course, I remember Karl Schaupp as a newsie on this paper; just as many of you old friends of his remember it, too. Together we can recall Karl when he attended the Santa Rosa schools and was graduated from the high school. The old family home was then in West Eighth Street and later in Sonoma Avenue. He was one of several children, and he recounted Thursday night how it was necessary for him to carry a newspaper route in order to earn a little money to help keep things going.

He left Santa Rosa to enter Stanford University in brilliant scholarship and later emerged from the medical college with fine attainments. He has gradually advanced as a specialist and consultant until he is a recognized authority in his specialized branch of medicine and enjoying a big practice.

Well, Doctor Schaupp was one of the principal guests and speakers at the annual dinner gathering of the medical societies of Sonoma, Solano, Napa, and Marin counties, an assemblage of a hundred physicians and surgeons who mingled together very happily, enjoyed the fine buffet supper and listened to their distinguished guest, the head of the California State Medical Association already referred to, and others. It was a very pleasing occasion. Other guests included Captain Greer, head of the Navy hospital at Mare Island, and a group of members of the staff, together with representatives of the Army Medical Corps.

After Dr. Dwight Murray of Napa had opened the after-dinner program, Dr. William Makaroff of Guerneville, vice-president of the Sonoma County Medical Society, was master of ceremonies in the absence of Dr. Clifford Carlson of Santa Rosa, the president. Routine business was presented by Dr. E. Dwight Barnett, Sonoma county health director and organization secretary.

Doctor Schaupp acknowledged the invitation to be present at the gathering, and he briefly and pointedly called attention to the emergency situations to which doctors had so splendidly responded in these war days in entering the medical corps of the military forces everywhere in the World War range, their attention to caring for the sick in their home communities, the charitable work they frequently undertake, and the continued effort to maintain the dignity and efficiency of the profession. The speaker was given an ovation. It might also be recounted that at the outset of his remarks he pleasingly referred to his newspaper-carrier days on *The Press-Democrat* and said, "On one occasion when I had overslept and Jim Ramage came to the house and rousted me out of bed, Senator Slater advised me then that it would be necessary for me to be on time if I expected to keep my job and make a success of myself in life." The medicos all joined in a hearty laugh at this reminiscence.

Hartley Peart, widely known San Francisco barrister, who is the counsel for the State Medical Association, discussed the fee question in connection with the treatment by physicians in compensation cases under the Workmen's Compensation Act. He cited the conferences that had been held in connection with unemployment insurance cases between himself and other representatives of the Association and federal men from the national capital.

Other speakers of the evening included the writer, who was introduced by Doctor Murray; Dr. Henry Rogers of Petaluma, former state president; Dr. George Kress, secretary of the state group; Dr. John Green of Vallejo; John Hunton, one of the officials of the Medical Association; Captain Greer, and others. Santa Rosa, Petaluma, Sebastopol, Sonoma, Healdsburg, Guerneville, and other places in Sonoma County were represented by many members of the medical profession. Dr. Fred O. Butler, director of the Sonoma State Home, was one of the widely known members of the Association introduced to the assemblage.

Reserving to the last one of the most important announcements of this occasion was the statement that today at the head offices of the California State Medical Association in the city by the Golden Gate a service flag will be unfurled in silent and impressive tribute to the fact that to date California has contributed to the World War services 2,000 doctors. That is something really worth celebrating.

Had almost forgotten that doctors also played golf, and they did so Thursday afternoon on the Sonoma golf links, the awards being golf balls. The winners were as follows:

Class A—Dr. J. P. Owen, U. S. N., Mare Island, and Dr. Frank Sheehy, San Francisco, low net.

Class B—Dr. "Pete" Green, Vallejo, low gross; Dr. Orville Chappell, low net.

Class C—Dr. Chester Marsh, Sebastopol, winner; Dr. Dwight Murray, Napa, low net; Dr. Robert Handlosser, Mare Island, low gross. This contest was said to be the really tough one of the series.—Santa Rosa *Press-Democrat*, July 31.

Dr. M. J. Rowe Is Superintendent of Mendocino State Hospital

Dr. Melvin J. Rowe has been appointed superintendent of Mendocino State Hospital, according to the announcement made from the office of Mrs. Dora Shaw Heffner, State Director of Institutions. Doctor Rowe has been assistant medical director at Norwalk State Hospital in the southern part of the state since 1925.

Friends of Dr. and Mrs. Rowe will welcome them back to Mendocino State Hospital, where from 1914 to 1925 Doctor Rowe was a member of the medical staff of the hospital and assistant superintendent. Both Dr. and Mrs. Rowe are graduates of Ann Arbor, Michigan. Doctor Rowe was transferred from Mendocino State Hospital to Norwalk in 1925.

The appointment of Dr. Theo K. Miller as superintendent of the Napa State Hospital is announced by Mrs. Dora Shaw Heffner, State Director of Institutions.

Doctor Miller, 48, had been acting superintendent since January 10 when Dr. I. E. Charlesworth, then head of the institution, became ill. Doctor Charlesworth died last February 28.

A graduate of the University of Southern California medical school, Miller previously was on the staff of the Patton State Hospital near San Bernardino for ten years, then served at the Camarillo State Hospital in Los Angeles County. He joined the Napa institution's staff in August, 1942.—*Ukiah Dispatch-Democrat,* July 30.

What Can Be Done to Save Medical Care (California Physicians' Service) Plan

When the question arises on what is causing the medical care program of the Vallejo Housing Authority and the California Physicians' Service to fall apart, and what can be done to save it, there are almost as many opinions as there are people concerned.

However, these opinions and the contributing facts from which these opinions are drawn, can be narrowed down to a point where the principal cause of the weakness of the program can be shown. The solution may be an entirely different matter.

Strange as it may seem, the process of creating life is the major factor in causing the unsound operation of the medical care program. Upsetting the apple cart of carefully prepared figures assembled by California Physicians' Service when it initiated the program was the birth rate of 100 per 1,000 population.

This birth rate, in final summary, used up 35 to 43 per cent of the cost of operation in the various projects.

The other factor, of long-neglected ailments now being treated, is not so important because few are the younger-type families living in the housing projects who have ailments "long neglected" and fewer still are those who are willing to take time off their war jobs to have the ailments treated.

Logically, if the California Physicians' Service could exclude maternity care from its lists of treatments, the program should work successfully. However, there is some doubt that it would, because so many people would be likely to withdraw, and at any rate it is now too late to exclude maternity care.

The best bet locally seems to be a general cutting down of outside expenses, such as administration and hospitalization, more treatment by staff physicians in better-equipped medical centers, a slight increase in rates charged tenants and 100 per cent participation.

If subscription to the medical care program could be made a condition of tenancy, just as are payments for electricity, water, gas, and other services, it is possible the program would operate highly successfully.

It is this involuntary participation which holds the absolute key and on it depends the final solution, if the present program is to be saved.—Editorial in the Vallejo *Evening News-Chronicle,* August 16.

Monte Sano Foundation Buys Burbank Hospital

Burbank, Aug. 18.—Purchase of the Burbank Hospital, headed by Dr. Elmer Thompson for the last two decades, today was announced by the Monte Sano Foundation, a nonprofit, nonsectarian eleemosynary corporation.

The local site was acquired in the form of a two-story house in 1907 and the present building was completed in 1925.

The Foundation plans to operate the Burbank Hospital as a general hospital for the welfare of the community. It will be manned by a regular staff of specialists in various fields and by a visiting staff of qualified physicians practicing in the Valley area. Though the regular staff and most of the visiting staff will be osteopathic physicians and surgeons now on the staff at Monte Sano Hospital, membership will be open to qualified practitioners of all schools, officials said. . . .—Hollywood *Citizen-News,* August 18.

Pointers on the Political Parade: California Youth Authority

The California Youth Authority, a comparatively new commission, has under its jurisdiction the Ventura School for Girls at Ventura, Preston School of Industry for Boys, and Nelles Correctional School for Boys at Whittier.

The other members of the Youth Authority are O. H. Close (chairman) and Harold A. Slane of Los Angeles. It is expected that all juvenile placements in correctional schools will be handled through this commission.

The members of the advisory panel who will select a third member of the Commission to fill the October 1 vacancy are C. C. Cottrell, San Jose, chairman, president of the Prison Association of California; the Rev. Joseph Mulkern, president of the California Conference of Social Work; Frank Belcher, Los Angeles, president of the State Bar Association; John M. Zuck, Los Angeles, president of the California Probation and Parole Officers' Association; Dr. Karl L. Schaupp, San Francisco, president of the California Medical Association; and John F. Brady, San Francisco, president of the California Teachers' Association.

The group will consider applicants for the position on September 11.—Vallejo *Times-Herald,* August 20.

Mosquitoes and the Menace of Malaria

The Bureau of Housing and Sanitation of the City of Los Angeles has recently investigated a relatively large number of complaints about mosquitoes. From a public health standpoint the Department is most interested in mosquitoes of a type that are known to transmit disease. Mosquito larvae have been collected from a number of locations in various parts of the city. It was found that most of the specimens were of the genus culex, important not only as a pest mosquito but also as a potential carrier of encephalitis, or sleeping sickness.

In a few areas large numbers of anopheles mosquitoes were found to be breeding. Fortunately, most of these were of the species, pseudopunctipennis. These do not normally invade homes and are probably of little significance as malaria carriers.

Recently, investigations made by the State and United States Public Health Service showed that some anopheles maculipennis are breeding in territory near the city limits. This type of mosquito enters homes freely, is a vicious biter, and is most important as a malaria vector.

Many of the pest mosquitoes were found to be breeding in barrels of water maintained for civilian defense fire-fighting purposes. Although the Department has repeatedly recommended properly covering these barrels or bi-weekly applications of a tablespoonful of fuel or Diesel oil, relatively few of these barrels have been properly protected.

The City Engineering and Water Departments and certain industrial plants have started eliminating the source by oiling and draining places under their jurisdiction. Mosquitoes at one large plant were so numerous as to interfere with production.

Mosquito control cannot be entirely effective until personnel, materials and equipment are provided for the control of all mosquito breeding areas. At the present time this department has no mosquito control funds available.—*Weekly Report,* Department of Health, City of Los Angeles.

Infant Disease Spread Reaches Alarming Rate

California, Kansas, Illinois, and Other States Report Serious Increase

Chicago, Aug. 17 (UP).—The American Medical Association today reported an "alarming increase" of infantile paralysis in widespread sections of the country.

The Journal of the American Medical Association said the disease may become more prevalent this year than at any time since 1940, when 9,770 cases were recorded.

"Through August 7, nearly 3,000 cases have been reported," *The Journal* said, "or more than twice as many as appeared during the similar period last year."

California Hit Hard

California, Texas, Oklahoma, and Connecticut appear to be most seriously affected, *The Journal* said. Recent reports, however, said Kansas is suffering the worst infantile paralysis outbreak in its history, with a peak expected some time next month.

The National Foundation for Infantile Paralysis notified Governor Andrew F. Schoeppel that it was placing every resource, including money if necessary, at the disposal of Kansas physicians and public health authorities.

Chicago Has 134 Cases

In the Chicago area, the spread of the disease was reaching the epidemic proportions with 93 cases reported this year. The total for Illinois was 134 cases, with 19 fatalities.

California recorded 111 new cases the week ending August 7, bringing its total for the year to 952.

Other states reported the following totals through August 7: Texas, 757; Oklahoma, 292; Kentucky, 51; Alabama, 46; Connecticut, 41.—Tucson *Citizen,* August 17.

MEDICAL JURISPRUDENCE†

Hartley F. Peart, Esq.
San Francisco

Discussion of Written Consent to Operation

In the case of *Keister* vs. *O'Neill,* 59 A. C. A. 512, decided June 28, 1943, by the California District Court of Appeal, the facts were these:

Plaintiff brought suit against a regularly licensed physician and surgeon who had performed an appendectomy upon her, joining in the action as defendant a hospital in which the operation was performed. Plaintiff's alleged cause of action arose out of certain acts performed by the physician after the completion of the operation. In substance, it was alleged in the complaint that the defendant physician performed an operation on the plaintiff for removal of her appendix and that immediately following the completion of the operation the hospital employees, acting under orders from defendant, administered a hypodermic injection of glucose into her body and in doing so negligently broke off the hypodermic needle in her left thigh.

A second cause of action set forth in the complaint was based substantially upon these facts with an additional allegation that the defendant had, in operating to remove the broken needle, used a spinal anesthetic without the consent of plaintiff or anyone authorized to act in her behalf, and further that the operation left an unsightly and disfiguring scar on her left thigh.

In a third alleged cause of action, plaintiff contended that the defendant physician and the hospital had failed to make a thorough examination to ascertain correctly the location of the broken needle.

After pleadings were filed by both defendants, plaintiff dismissed the action as to the hospital, choosing to proceed only against the defendant physician and surgeon. The trial court rendered a decision in favor of the physician on the questions, first, whether a spinal anesthetic had been used without plaintiff's consent and if so, whether any damage resulted therefrom; and, second, whether the physician, in operating to remove the needle, failed to make a thorough examination to locate it and if so, whether any damage resulted from such failure.

At the trial of the case the facts brought out were that plaintiff, a 17-year-old married woman, was taken to the hospital by her husband for an appendectomy, both parties signing a written consent to the operation. The operation performed by defendant was complicated by the position of the appendix and an unusual length of time was consumed before its completion. Defendant then directed that a hypodermoclysis be administered. In the process a needle was broken off in plaintiff's left thigh. X-rays were immediately taken and it was decided to postpone removal for the time being, as plaintiff was just coming out of the general anesthetic. A week later, additional x-rays were taken and the needle removed by defendant. Plaintiff fully recovered without any apparent trouble from both operations.

Although no consent from the plaintiff or her husband had been obtained for the operation to remove the needle, plaintiff had conceded in the pleadings that this operation had been performed with the full knowledge and consent of her mother-in-law, and that she was bound by this consent. The testimony was conflicting on the use of the spinal anesthetic. Plaintiff's mother-in-law testified that she told defendant definitely not to administer a spinal anesthetic and plaintiff's husband gave testimony to the same effect. The defendant physician, as opposed to this testimony, stated that the only remonstrance about the use of a spinal anesthetic was made after the plaintiff's departure from the hospital when the mother-in-law said they would have opposed the use of such an anesthetic.

Prior to the appendectomy, the plaintiff and her husband had both signed a written authority to operate, consenting to the administration of whatever anesthetic and the performance of whatever operations might be deemed necessary or advisable. No contention was made that either the appendectomy or the operation for the removal of the hypodermic needle had been performed unskillfully or with any ill effects to plaintiff other than the allegation that plaintiff's thigh was disfigured.

The Appellate Court affirmed the trial court's judgment on these facts for the defendant on all counts of the complaint, overruling plaintiff's contention that the written consent to the appendectomy only operated for the benefit of the hospital. On the question of whether the spinal anesthetic prior to the removal of the needle had been administered without obtaining a proper authorization, the Appellate Court again affirmed the lower court's judgment for defendant, stating that although the testimony was conflicting, there was no damage to the plaintiff shown by the use of a spinal anesthetic.

This case again illustrates the importance of obtaining the written consent of a patient or, in the case of a minor, the written consent of his parents or other legal guardian, before performing any operation. The written consent to the appendectomy fully protected both the doctor and the hospital as to that operation from any charge of operating without consent, but a successful action for operating upon the plaintiff without first obtaining her consent and the consent of her husband in the case of the removal of the broken needle might well have been maintained if the plaintiff had not conceded the authority of her mother-in-law to furnish such consent. Even though an operation to remove the needle was necessary to conserve and protect the plaintiff's life and health, more than a week elapsed after the needle was broken off in the plaintiff's thigh before the operation to remove it was performed. It was inadvisable for the physician to undertake the removal of the needle without first obtaining the written consent of both the plaintiff and her husband. Although his reliance upon the mother-in-law's consent did not result in a judgment against him, the decision might have been otherwise in the absence of plaintiff's admission that this consent was binding upon her.

Paul Ehrlich (1854-1915).—Of his achievements, the discovery of "606" is the most famous. During the first World War, salvarsan undoubtedly prevented epidemic syphilis. In the field of immunity, Ehrlich devised the so-called "side chain theory." Once, enthusiastically explaining this theory to his dinner companion, Prof. William Bulloch, he unceremoniously grabbed a batch of souvenir cards nearby to demonstrate his figures. Ehrlich, together with Metchnikoff, was awarded the Nobel Prize for work on immunity in 1908.—Warner's *Calendar of Medical History.*

Jaime Ferran y Clua (1849–1929).—Another of the many biological developments that had the first World War for their proving ground was the cholera vaccine of the Spanish bacteriologist, Ferran. Thirty years previously he had been freely criticized for his active immunization against cholera, but with war it received the recognition it deserved. Between the years of 1881 and 1885, Ferran had actively immunized 50,000 persons against cholera in Valencia, Spain, advocating similar treatment for other infections.—Warner's *Calendar of Medical History.*

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† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

LETTERS†

Concerning Mexican Congress on Cancer:

San Francisco, August 18, 1943.

Dr. Gabriel Vazquez Arroyo
Edificio Lutecia No. 101-123
Guadalajara, Jal., Mexico

My dear Doctor Arroyo:

Dr. George H. Kress, Secretary-Editor of the California Medical Association, placed your letter in my hands as chairman of the Cancer Committee of the California Medical Association.

I am very interested indeed that you are to hold the first Mexican Cancer Congress, and I hope we will be able to send a representative to your meeting. At this time in the world's history everybody is extremely busy and occupied, and I doubt if I can find anyone who can give the time to attend your interesting meeting.

This is most unfortunate, as we would like to coöperate. I want you to know that you have our best wishes for a successful meeting, and may I ask that you send us the reports which will come out of the Congress so that we may have them in our files.

With cordial greetings,

Sincerely yours,

Harold Brunn.

Concerning Medical Literature Sent to Military Camps in California—Letter of Appreciation:

(copy)

Station Hospital
Office of the Surgeon
Fort Ord, California,
13 August, 1943.

California Medical Association
450 Sutter Street
San Francisco, California

Attention: C. M. A. Postgraduate Committee

Gentlemen:

The receipt of a shipment of medical literature from you is gratefully acknowledged.

These books and pamphlets have already been placed in our hospital library and are being used daily by the medical officers and other personnel of this hospital. Many of the publications received filled existing gaps in several series of publications.

Sincerely thanking you for this literature, I am

Yours truly,

(Signed) Edward H. Frick,
First Lieut., MAC, Asst. Adjutant.

Concerning Request from Sheriff of County of Los Angeles:

(copy)

State of California
Department of
Professional and Vocational Standards
Board of Medical Examiners

August 23, 1943.

George H. Kress, M. D., Editor,
Addressed

Dear Doctor Kress:

We are enclosing a copy of a letter recently sent to our Special Agent in our Los Angeles office regarding one "Grant Wyatt Terry." We also attach a photograph of this individual and a photostatic copy of his application for an operator's license.

You will note the request of the Sheriff of Los Angeles County that we forward this material to the California State Medical Journal for publication. We are, therefore, sending same to you for whatever attention you care to give.

Very truly yours,

(Signed) Frederick N. Scatena, M. D.,
Secretary-Treasurer.

⁂

County of Los Angeles
Los Angeles, Calif.,
August 16, 1943.

Subject: Grant Wyatt Terry, File A-29918

Mr. S. W. Brooks,
Inspector, State Medical Department
State Building
Los Angeles, California

Dear Sir:

Pursuant to my telephone conversation with you this date, I am enclosing photograph and photostatic copy of application for California Operator's license issued to one Grant Wyatt Terry, the latter bearing his signature.

This man is a possible suspect in a murder case where victim was found brutally strangled the morning of July 27, 1943, in this county, which is being investigated by this Department under above file number.

Will you please forward above-mentioned enclosures to the proper authorities in Sacramento with the request that they be inserted in the next issue of the California State Medical Journal, along with the following:

"July 27, 1943, Mrs. Ora E. Murray was found brutally strangled in Los Angeles County, and this office is desirous of obtaining any information regarding the treatment of any person for fingernail scratches on the body and treatment for a bruised or lacerated penis or testicles possibly inflicted by victim's teeth or fingernails. Accompanying photograph is of one Grant Wyatt Terry wanted by this office as a possible suspect.

"Any physician having treated this suspect or any other person for injuries such as above described, please contact Eugene W. Biscailuz, Sheriff, Los Angeles County."

Thank you for your coöperation in this matter.

Very truly yours,

E. W. Biscailuz, *Sheriff*
(Signed) By W. J. Penprase, Inspector,
Bureau of Investigation.

Sir Almroth Wright (B. 1861).—Because of his successful typhoid inoculation of 3,000 soldiers in India (1898-1900), followed later by the vaccination of the entire British Expeditionary Force during the South African War, Almroth Wright may well be regarded as the pioneer in general vaccinotherapy. He carried out many important researches in parasitic diseases and acted as consulting physician to the army in France during the First World War. Most physicians associate Wright with the opsonic index, which he introduced, for measuring the protective substances in the blood.—Warner's *Calendar of Medical History.*

Physicians are—some of them—so pleasing and conformable to the humor of the patient, as they press not the true cure of the disease; and some others are so regular in proceeding according to art for the disease, as they respect not sufficiently the condition of the patient. Take one of a middle temper; or, if it may not be found in one man, combine two of either sort.—Sir Francis Bacon.

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† California and Western Medicine does not hold itself responsible for views expressed in articles or letters when signed by the author.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 9, September, 1918

EXCERPTS FROM EDITORIAL NOTES

"Let our object be, our country, our whole country, and nothing but our country."—Webster.

A War Message from President Van Zwalenburg.—The manner in which the medical profession has responded to the call for war service is cause for pride and gratification. Whether soliciting or contributing to war funds, whether making draft examinations or rendering gratuitous services to dependents of soldiers, called to enlist for Red Cross, Army or the Navy, the medical profession has been found true to its traditional readiness to answer the call of distress, and has pushed forward with the energy of the man whose whole soul is dedicated to the cause. . . .

In a recent letter the President of the American Medical Association, Dr. Arthur Dean Bevan, calls upon the officers of the State Societies to assist in the organization of the profession for this war. He asks that we furnish a sufficient supply of medical officers for the needs of the Army, and that we do it in the way which will least disturb the civilian communities, hospitals, and medical schools. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Plastic Surgery of Nose and Ears: A Further Contribution," by Grant Selfridge, M.D., San Francisco.—Thirty years ago, June 4, 1887, the late Dr. John O. Roe of Rochester, New York, published in the Medical Record an article on "The Deformity Termed 'Pug Nose' and Its Correction by a Simple Operation." In the same journal, issue of July 18, 1891, he published another article on the "Correction of Angular Deformity of the Nose by a Subcutaneous Operation," and two years later, in the *New York Medical Journal*, March 25, 1893, still another on "The Correction of Deformities of the Nose Resulting from Abscess of the Nasal Septum." These articles were the first to appear in this country dealing with nasal plastics. It is to this author, therefore, that all credit is due for all that has developed in this branch of cosmetic surgery since that time, in Europe as well as here. . . .

From an Article on "Social Problems of the War," by Dr. H. G. Irvine, Director, Bureau of Venereal Diseases, State Board of Health, and Dr. W. M. Dickie, Sanitarian, Bureau of Venereal Diseases, State Board of Health.—Inasmuch as the program includes a paper on the social service and law enforcement phases of this problem, we will confine ourselves to the *strictly medical side*. . . .

California may well be proud that it was one of the first states to answer the call and make an adequate appropriation for the organization of the Bureau of Venereal Diseases, which should direct and coördinate the campaign in coöperation with the military and naval authorities. The program which this Bureau has sought to put into practice has included an attack from all angles, but as previously stated, we shall in this paper deal only with the *strictly medical part of it*. . . .

From an Article on "Intestinal Obstruction," by Harlan Shoemaker, M. D., Los Angeles.—An analysis of the histo-

(Continued in Back Advertising Section, Page 32)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.
Secretary-Treasurer

Board Proceedings

A regular meeting of the Board of Medical Examiners was held at the Elks Club, 607 South Park View, Los Angeles, August 9 to 12, 1943, at which approximately seventy oral examinees presented themselves for examination and eighty-one physicians and surgeons wrote the regular written examination.

Legal hearings were conducted at which the following actions were taken:

Paul Franklin Marling, M. D. Found guilty August 10, 1943, and placed on five years' probation without narcotic privileges and other specified terms. (Section 2390, Business and Professions Code.)

James Lee Robinson, M. D. Found guilty August 10, 1943, and placed on five years' probation without narcotic privileges and other specified terms. (Section 2390, Business and Professions Code.)

* * *

The next regular meeting of the Board of Medical Examiners will be held in Sacramento, October 18 to 21, 1943.

News

"The American Medical Association will hold its 1946 convention in the San Francisco Civic Auditorium, the San Francisco Tourist and Convention Bureau announced yesterday." (San Francisco *Examiner*, July 12, 1943.)

"No headlines herald the progress of the medical profession in its efforts to distribute adequate medical care to every section of the country. As usual, it serves in silence. The *American Medical Journal* points out that there are two objectives which the doctors seek: First, the best distribution of available resources of medical personnel and the health protection of the largest number of people; second, the doing of this in such a way as to preserve the rights and advantages that inhere in local self-government. . . ." (Chico *Enterprise*, July 7, 1943.)

"Dr. Howard C. Naffziger, 59, San Francisco brain specialist who was called to London to work with the British Research Council, today held an honorary fellowship in the Royal College of Surgeons. The high award was made yesterday to Doctor Naffziger, who is chairman of the Committee of Neurological Survey of the U. S. National Research Council, in recognition of his leadership in organizing surgery on the home front, press dispatches said." (San Francisco *Call-Bulletin*, July 22, 1943.)

"The Stanislaus County Board of Supervisors, meeting here today, was requested by the State Health Department, bureau of maternal child help, to permit the use of county hospital facilities in maternity cases involving wives of soldiers, with full reimbursement to be made. . . . The facilities would be offered to wives of service men from private to sergeant, fourth grade. . . . The reimbursement to the county would cover only actual cost. . . ." (Modesto *Bee*, July 12, 1943.)

"Illustrated with moving pictures, members of the San Joaquin County Medical Society will hear a discussion of

(Continued in Back Advertising Section, Page 34)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

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SIMILAC
A FOOD FOR INFANTS
M&R DIETETIC LABORATORIES, INC.
COLUMBUS, OHIO.
NET WEIGHT ONE POUND
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Continue until Weaning

No food (except breast milk) is more highly regarded than Similac for feeding the very young, small twins, prematures, or infants who have suffered a digestive upset. Similac is satisfactory in these special cases simply because it *resembles breast milk so closely,* and normal babies thrive on it for the same reason. This similarity to breast milk is definitely desirable—*from birth until weaning.*

A powdered modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butterfat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil, and cod liver oil concentrate.

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One level tablespoon of Similac powder added to *two* ounces of water makes *two* fluid ounces of Similac. This is the normal mixture and the caloric value is approximately 20 calories per fluid ounce.

SIMILAC } **SIMILAR TO BREAST MILK**

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Due to British war restrictions, gold foil has been eliminated and other slight changes have been made on the *outside* of the familiar Johnnie Walker bottle—but *inside* good old Johnnie Walker whisky remains unchanged.

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BLACK LABEL 12 YEARS OLD

Both 86.8 proof

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

CANADA DRY GINGER ALE, INC.
New York, N. Y. • *Sole Importer*

Bequest Forms: Unto the Physicians' Benevolence Fund of the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $——— for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association. a nonprofit corporation of California, the sum of $———, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be paid to and become a part of the Physicians' Benevolence Fund of the California Medical Association as said fund is established and maintained by said Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I hereby give and bequeath unto the Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be expended by said corporation for the benefit and as a part of the Physicians' Benevolence Fund of the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California, for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association the following described real property situate in the county of ——— State of California, and more particularly described as follows, to-wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be held as a part of the Physicians' Benevolence Fund of the California Medical Association, the income whereof shall be used for the purposes of said fund as it is established and maintained by the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

---

* Correspondence for the Physicians' Benevolence Committee may be addressed to the C. M. A. office or to Axcel E. Anderson, Chairman, 1759 Fulton Street, Fresno.

“don’t smoke”...

is advice hard for patients to swallow. May we suggest, instead, *Smoke “Philip Morris”?*
Tests showed 3 out of every 4 cases of smokers’ cough cleared on changing to Philip Morris. Why not observe the results for yourself?

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Superintendent, V. W. OLNEY

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BOOK REVIEWS

(Continued from Front Advertising Section, Page 22)

Your Arthritis: What You Can Do About It. By Alfred E. Phelps, M. D. With an Introduction by R. Garfield Snyder, M. D. Cloth. Price, $2. Pp. 192, with illustrations by James MacDonald. New York: William Morrow & Company, 1943.

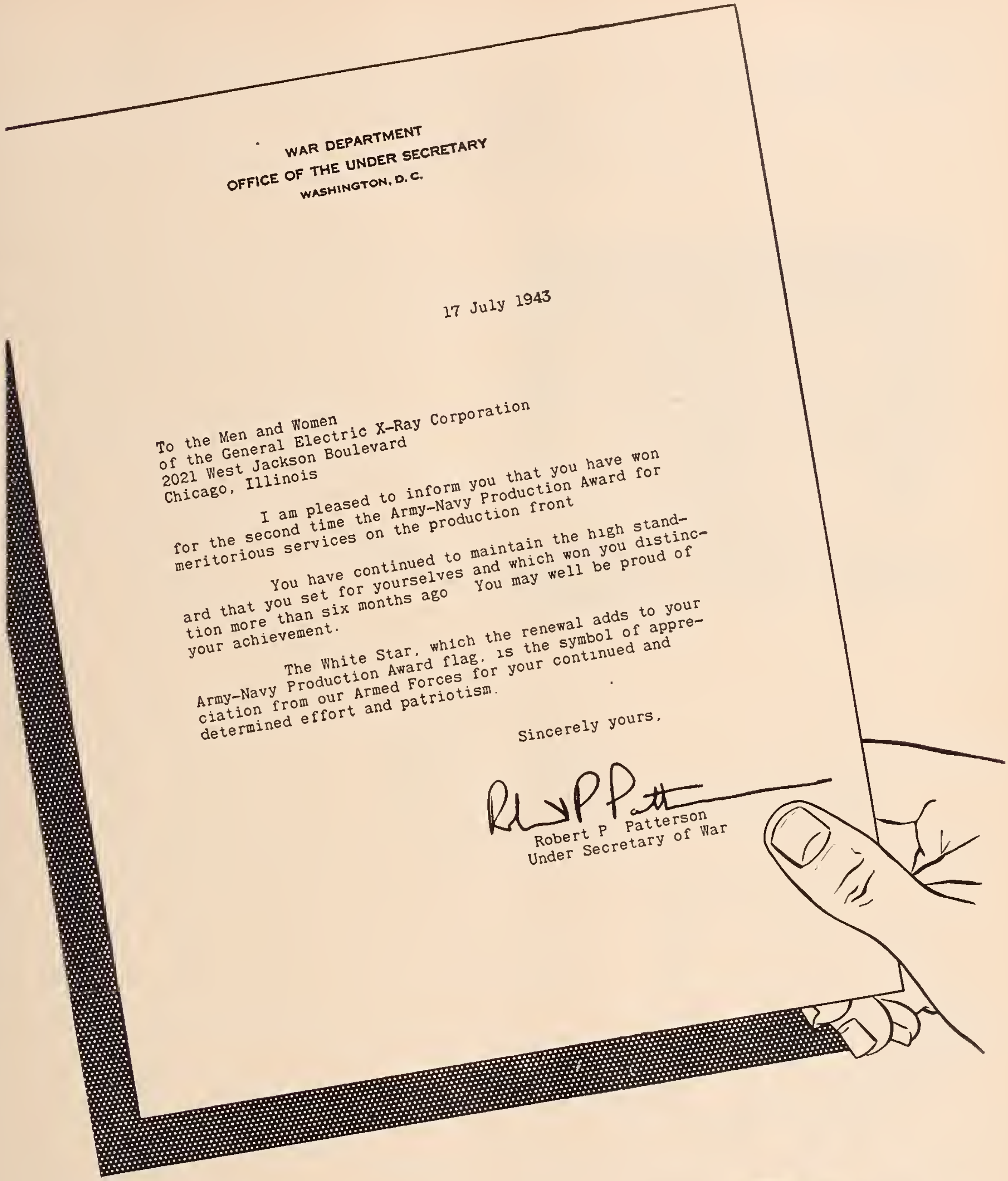
To conquer chronic arthritis and to conquer it without loss of time requires the complete coöperation of the patient and the physician. This relationship can be adequately attained and intelligently pursued only when the patient possesses a fundamental knowledge of the nature of the disease and its problems. In an attempt to acquaint the arthritic with a knowledge of the fundamentals of his disease, the author deemed it advisable to approach the subject from several directions, each more or less independent.

The author states it is his hope that the reader especially interested in obtaining an understanding of arthritis will gain that insight into its problems and acquire that attitude of mind which will result in his intelligent coöperation with his physician by performing those activities which are beneficial, by avoiding those which are detrimental, by seeking those conditions which are helpful and by shunning those which are harmful.

A Manual of Otology, Rhinology, and Laryngology. By Howard Charles Ballenger, M. D., F. A. C. S., Associate Professor of Otolaryngology, Northwestern University School of Medicine, Chicago, Illinois. Surgeon, Department of Otolaryngology, Evanston Hospital, Evanston, Illinois. Second edition, enlarged and thoroughly revised. Cloth. Price, $4. Pp. 334, illustrated with 114 engravings and three color plates. Philadelphia: Lea & Febiger, 1943.

This volume is a small, concise textbook on diseases of

(Continued on Page 32)



WAR DEPARTMENT
OFFICE OF THE UNDER SECRETARY
WASHINGTON, D. C.

17 July 1943

To the Men and Women
of the General Electric X-Ray Corporation
2021 West Jackson Boulevard
Chicago, Illinois

I am pleased to inform you that you have won for the second time the Army-Navy Production Award for meritorious services on the production front

You have continued to maintain the high standard that you set for yourselves and which won you distinction more than six months ago You may well be proud of your achievement.

The White Star, which the renewal adds to your Army-Navy Production Award flag, is the symbol of appreciation from our Armed Forces for your continued and determined effort and patriotism.

Sincerely yours,

Robert P Patterson
Under Secretary of War

G-E STANDARDS ARE SET UP TO BE MAINTAINED—IN WAR AND IN PEACE

ARMY E NAVY

GENERAL ELECTRIC X-RAY CORPORATION
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. . . to Build Better Citizens

Every physician knows, from personal observation, that too many children in too short a period of time endangers the health of the mother, and beclouds the outlook of the children from many standpoints—that of parental training, living conditions, education, and in many cases, sufficient money for food and clothing. Carefully planned families, with children properly spaced, make the best American citizens.

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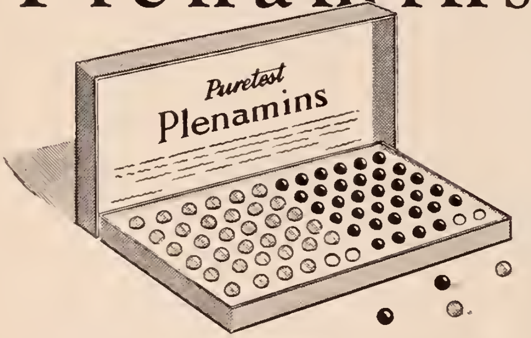

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WITH LIVER & IRON

The Owl Drug Co

131 STORES ON PACIFIC COAST

BOOK REVIEWS

(Continued from Page 30)

the nose, throat, and ear, which emphasizes anatomy, etiology, symptoms, and diagnosis; and includes only the usually accepted general and local treatments.

The present work has been prepared based upon the larger and more comprehensive Seventh Edition of Ballenger's "Diseases of the Nose, Throat, and Ear." The text has been prepared primarily for the undergraduate medical student, but it is the hope of the author that the general physician, nurse, and occasionally the otolaryngologist will find the book convenient for reference.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 204)

ries diagnosed intestinal obstruction in cases occurring at the Los Angeles County Hospital during the years of 1915-16-17 show some very interesting facts that may be profitably considered at this time. It was Agassiz, I believe, who said, "Study nature and not books," and I have found the rehearsing of these histories much more interesting from the standpoint of intestinal obstruction than any textbook article I ever read on the subject. No one history is complete. No one history covers all the symptoms of this very complicated condition, but when all the histories are viewed together as a whole there is not a single point, I believe, that has been mentioned on the subject of intestinal obstruction that has not been brought out in this, that, or the other case. It is in an effort to focus the attention of the profession on some of the outstanding symptoms of intestinal obstruction that a review of these histories has been undertaken. . . .

(Continued on Page 34)

MEDICINE DESERVES IT

ORGANIZED medicine has always struggled to maintain high standards of professional practice. Ethical purveyors of commercial therapeutic products have always applauded the battle for quality. The California Association of Dispensing Opticians strives to maintain standards of optical work which thoroughly justify the confidence of the men in the medical specialty of Ophthalmology.

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THE POTTENGER SANATORIUM AND CLINIC

For Diseases of the Chest *Monrovia, California*

AN INSTITUTION FOR DIAGNOSIS AND THERAPY

(Established 1903)

CHOICE rooms and bungalows at rates ranging from $37.50 up, including routine medical and nursing services, interim physical, x-ray and laboratory examinations, ordinary medicines and pneumothorax. A charge is made for the first complete examination.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases. Separate institution for children.

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THE SOUTHARD SCHOOL

For the Education and Psychiatric Treatment of Children of Average and Superior Intelligence. Boarding Home Facilities.

TOPEKA, KANSAS

TWENTY-FIVE YEARS AGO

(Continued from Page 32)

Excerpts from Military News—One Thousand New Nurses Needed Each Week.—Surgeon-General Gorgas has called upon the American Red Cross, as the chief nurse-recruiting agency of the Army, to employ every possible means to increase the enrollment of nurses for immediate assignment to duty. He asked that at least one thousand nurses a week be enrolled for the next two months.

The increase in the Army, both at home and abroad, has necessitated a proportionate increase in the number of nurses in the service. The Army today is growing faster than the nurse corps is increasing, and as the armies overseas enter the front-line trenches in greater numbers the greater will be the need for nurses in the Army Nurse Corps. . . .

White Star to Army-Navy "E" Flag.—Announcement of a second award for excellence of war production to the General Electric X-Ray Corporation, Chicago, was received by the company in a letter from Robert P. Patterson, Under Secretary of War. This award adds a white star to the Army-Navy "E" flag which has flown over the company's plant since the coveted industrial prize was first presented as of January 26 of this year.

The letter announcing the second award reads as follows:

"I am pleased to inform you that you have won for the second time the Army-Navy Production Award for meritorious services on the production front.

"You have continued to maintain the high standard that you set for yourselves and which won you distinction more than six months ago. You may well be proud of your achievement.

"The White Star, which the renewal adds to your Army-Navy Production Award flag, is the symbol of appreciation from our armed forces for your continued and determined effort and patriotism."

(Signed) ROBERT P. PATTERSON.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 204)

'Prophylaxis, Care, Pathology and Treatment of Chemical Casualties' tonight at 7:45 o'clock in the Medico-Dental Clubrooms. Leading the discussion will be Dr. Rodney Beard of the Stanford Medical School and Dr. Troy Daniels of the University of California Medical School." (Stockton *Record*, July 8, 1943.)

"Two high hurdles stand between Nathan S. Housman, former San Francisco surgeon, and his proposed resumption of medical practice, parole and medical authorities said yesterday. Suggestions that his license be restored have been made to Allen Moore, parole officer, in whose custody Housman has been since his release from San Quentin eighteen months ago. Housman was sentenced to serve one to fourteen years after being convicted on six counts of perjury and falsification of evidence. Moore said yesterday that shortly after granting Housman permission to marry, he recommended to the parole board that the former surgeon's parole be terminated. Such action, which Moore said yesterday may not be taken for some time, would permit Housman to apply to the State Board of Medical Examiners for restoration of his license. . . ." (San Francisco *Examiner*, July 14, 1943.)

"Joseph P. Michieli, 70, convicted Wednesday by a jury on charges of violating the Pure Foods and Drug Act, was fined $500 yesterday by Federal Judge Michael J. Roche. Judge Roche also imposed a sentence of thirty days each in the county jail on the two charges, with the provision that if the fine was paid the sentence would be suspended. Michieli immediately paid the fine. The second count of

(Continued on Page 36)

There's no rule about the length of a war, and no telling how great the sacrifices needed to win it. All we know is that it *must be won.*

We hope and pray that the *next* generation will be spared—that our lads of fourteen and fifteen are destined for something else but the horrors of war and the fields of battle.

We hope that we, of this generation, may transmit to the next generation a world in which ruthless savagery and killing have ceased . . . a world in which they may live and work in peace.

America must not lose this war—*dare* not lose it! We must win as *quickly* and completely as possible. If we win in time, hundreds of thousands of lives will be saved, and the youths of today will build the greater America of tomorrow.

It takes *money* to provide our fighting men with planes, tanks, guns and ships—tens of billions of dollars. It takes *War Bond* money—from you, and you, and you—regularly—every payday—10% of your income, at least—more, if you can.

Your Government will give you back $4 in 10 years for every $3 you invest now—$25 for each $18.75 Bond you buy. And your investment is backed and guaranteed by all the strength of the world's most powerful nation. The better we arm our *men,* the more lives of our *boys* will be spared, and the sooner will their future be assured.

Knowing this to be true—knowing that War Bonds will help save our country—the lives of our fighting men—yes, even the lives of those who are mere boys now . . .

Can you possibly *not* put every dollar you can scrape together into War Bonds?

FACTS
ABOUT WAR BONDS

1. War Bonds cost $18.75 for which you receive $25 in 10 years—or $4 for every $3.
2. War Bonds are the world's *safest* investment — guaranteed by the United States Government.
3. War Bonds can be made out in 1 name or 2, as co-owners.
4. War Bonds *cannot* go down in value. If they are lost, the Government will issue new ones.
5. War Bonds can be cashed in, in case of necessity, after 60 days.
6. War Bonds begin to pay interest after 1½ years.

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Indications	Formula
For all genito-urinary infections, particularly the irritated bladder of Prostatics	Calcium Carbonate Magnesium Carbonate Sodium Chloride Sodium Phosphate Sodium Bicarbonate
Pre- and Postoperative Treatment	
Fluid Depletion	
Indicated in combinations with Sulfa therapy	

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Graduate School of Medicine
(In affiliation with COOK COUNTY HOSPITAL)
Incorporated not for profit

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SURGERY—Two Weeks Intensive Course in Surgical Technique starting September 6 to 20, October 4 and 18, and every two weeks throughout the year.

MEDICINE—Two Weeks Intensive Course starting October 4. One Month Course in Electrocardiography and Heart Disease.

FRACTURES & TRAUMATIC SURGERY—Two Weeks Intensive Course starting October 18.

GYNECOLOGY—One Week Personal Course in Vaginal Approach to Pelvic Surgery starting November 1. Clinical and Diagnostic Courses.

OBSTETRICS—Two Weeks Intensive Course starting October 4.

ANESTHESIA—One Week Course in Continuous Caudal Anesthesia for Obstetrics.

OPHTHALMOLOGY—Two Weeks Intensive Course starting September 27. Course in Refraction Methods October 11.

OTOLARYNGOLOGY—Two Weeks Intensive Course starting September 13.

ROENTGENOLOGY—Courses in X-Ray Interpretation, Fluoroscopy, Deep X-Ray Therapy every week.

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Specialized care of Convalescents; also NERVOUS, MENTAL and ALCOHOLIC Patients. Experienced Staff for the application of INSULIN and ELECTRIC SHOCK Therapies and for the CONDITIONED REFLEX TREATMENT of ALCOHOLISM.

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MRS. A. S. ALEXANDER, *President* Telephone: BELMONT 40

BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

the charges brought him two years' probation. The trial, which lasted five days, involved the alleged curative properties of a patent medicine called "Caladin." Assistant U. S. Attorney Al J. Zirpoli prosecuted the case." (San Francisco *Recorder*, July 2, 1943.)

REPORT OF EXAMINATION: LICENTIATE APPLICANTS

Frederick N. Scatena, M.D., Secretary Treasurer of the Board of Medical Examiners of the State of California, reports results of the written examination held in San Francisco, June 29, 30, and July 1, 1943. The examination for physicians and surgeons covered nine subjects and included ninety questions; the examination for chiropodists covered six subjects and included sixty questions; and the examination for drugless practitioners covered seven subjects and included seventy questions. An average of 75 per cent is required to pass. One hundred and thirty-seven applicants wrote the examination.

The highest mark for physicians and surgeons (91-7 9 per cent) was made by Herbert Nils Hultgren, San Francisco, a graduate of the Stanford University School of Medicine, June 13, 1943.

The following is a list of successful applicants:

PHYSICIANS AND SURGEONS

NAME	SCHOOL
Abendroth, John Russell *San Francisco*	Stanford U. Sch. of Med., '43
Alexander, Harold Bazil *Rochester, Minnesota*	Univ. of Minn. Med. Sch., '43
Aycinena-Echeverria, Juan Fernando, *San Francisco*	Univ. of Guatemala Med. Sch., '40

(Continued on Page 38)

Consistent Performance

★ Unchanging, the Naval Observatory clock at Arlington has ticked on for decades. Its unvarying time is the accepted standard throughout the nation. The same consistent performance may be expected from PITOCIN*. Rigid standardization and marked stability assure the same reaction today as yesterday and the day before.

★ PITOCIN'S potent oxytocic principle, negligible amount of pressor factor, low protein content and freedom from impurities assures stimulation of uterine contracture, no appreciable rise in blood pressure and a minimum possibility of reactions—true uniformity.

★ Chief indications for PITOCIN (alpha-hypophamine) are: medical induction of labor; stimulation of uterus, in properly selected cases, during labor; prevention of postpartum hemorrhage and bleeding following curettage; and treatment of postpartum and late puerperal hemorrhage.

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USE Mailway Banking

FOR SAVINGS AND CHECKING ACCOUNTS

For the convenience of your business or household — a Mailway checking account. For safe and systematic accumulation of a cash reserve—a Mailway savings account. Both are available to you, affording quick reliable service from one of the oldest and strongest banks in the West. Open a Mailway account today.

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CROCKER FIRST NATIONAL BANK
OF SAN FRANCISCO
California's Oldest National Bank

Member Federal Deposit Insurance Corporation
ONE MONTGOMERY STREET

BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

NAME	SCHOOL
Bachrach, Emil *San Francisco*	Univ. of Vienna, Austria, '19
Bateman, Olive L. *Oakland*	Univ. of Minn. Med. Sch., '41
Beaghler, Harry Edward *Hollywood*	Univ. of Neb. Coll. of Med., '37
Bethard, William Frederick *San Francisco*	Rush Med. Coll., Ill., '42
Bissell, Charles Lewis *Los Angeles*	Stanford U. Sch. of Med., '43
Brauer, Raymond Oliver *San Jose*	Coll. of Med. Evang., '43
Brown, Robert Glenn *San Francisco*	Stanford U. Sch. of Med., '43
Bryan, John Ruggles *San Francisco*	Harvard Med. Sch., Mass., '43
Cannon, Robert Lee *San Francisco*	Indiana U. Sch. of Med., '42
Carpenter, Gurth Ernest Beverly Hills	U. of Edinburgh Fac. of Med., Scotland, '31
Castro, Amos John, Jr. *San Francisco*	Louisiana State U. Sch. of Med., '42
Clary, David Temple *San Francisco*	Creighton U. Sch. of Med., '43
Clerou, Romain Pierre *San Francisco*	Creighton U. Sch. of Med., '43
Condie, Robert Stevens *San Francisco*	Stanford U. Sch. of Med., '43
Cowan, John Francis *San Francisco*	Stanford U. Sch. of Med., '43
Crail, Howard Whitfield *San Francisco*	Northwestern U. Med. Sch., Illinois, '42
Cramer, Hugh Grant *Campbell*	Stanford U. Sch. of Med., '43
Culiner, Morris Michael *San Francisco*	Univ. of Toronto, Fac. of Med., Canada, '42
Cundiff, Richard John *San Francisco*	Harvard Med. Sch., Mass., '43
Curtis, Emerson C. *Payson, Utah*	U. of Pa. Sch. of Med., '42

(Continued on Page 40)

ANNOUNCEMENT

(Reading Time: 2 minutes)

UNDER PRESENT CONDITIONS it is apparent that there may not be enough Camp Supports to fill the increasing demand from physicians, surgeons and patients as quickly as usual.

A year and a half ago we published special announcements to the thousands of dealers who dispense our goods urging them to concentrate their service where it would do the most good to the greatest number who have worn them and need them, and to the physicians and surgeons who rely on them in their practice.

Requirements have mounted steadily since, due to the increasing number of women and older men in war work who require professionally accepted anatomical supports to maintain their health and efficiency. This situation has added heavily to the normal demand for Camp Anatomical Supports needed for postoperative, hernial, orthopedic and other conditions.

With the increasing demand for our supports on one hand and the scarcity of material and labor on the other, the situation is growing more complex and acute for dealers and ourselves.

★ ★ ★

We wish to assure members of the medical profession—especially those who have communicated with us—that everything possible is being done under prevailing circumstances to maintain evenly rationed deliveries in fairness to our distributors and you.

We request your indulgence if service is slower than heretofore. In the event that delayed service hinders treatment of specific urgent cases—we shall do everything in our power to facilitate service upon word from you.

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● **During these trying times substitutions are often resorted to and we respectfully suggest that patients be warned regarding acceptance of inferior substitutions or unscientific garments lest therapeutic objectives become endangered.**

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A general hospital of 225 beds operating an accredited School of Nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and operated by the French Mutual Benevolent Society through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons.

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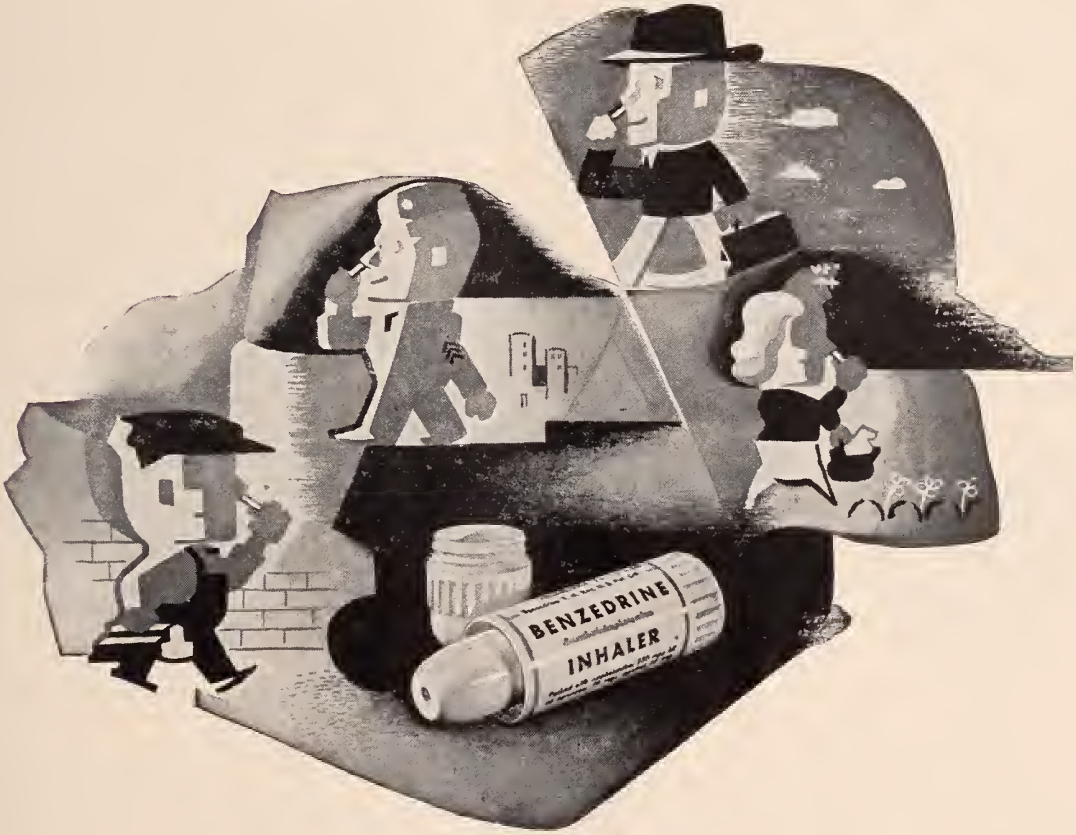

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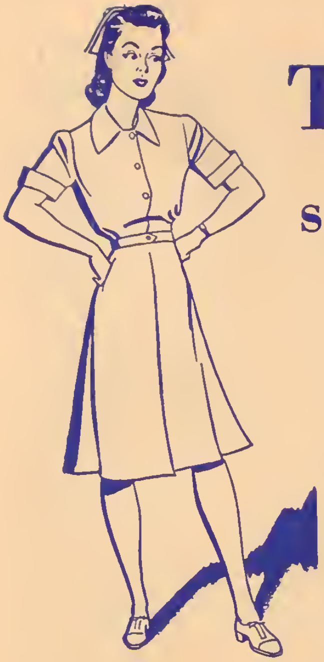

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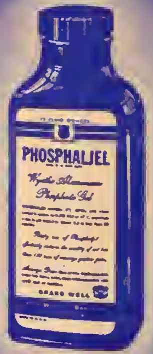

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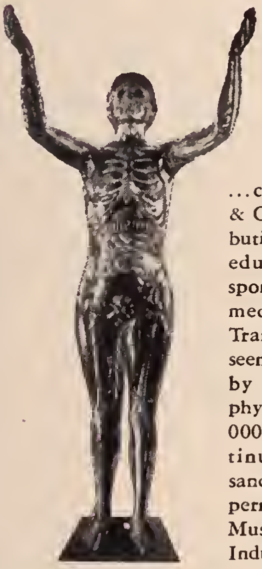

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Alameda County Medical Association
2404 Broadway, Oakland
President, Clifford W. Mack, Livermore Sanitarium, Livermore.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
President, Charles E. Plumb, 310 Main Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Secretary, J. M. Boomer, American Trust Building, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, William G. Milholland, 711 Bank of America Building, Fresno.
Secretary, Jerome A. Thormann, 2607 Fresno Street, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Charles C. Falk, Sr., 507 F Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, T. E. Bartholomew, 319 Third Street, Calexico.
Secretary, Henry Forcher, 319 Third Street, Calexico.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, William I. Shultz, 408 N. Main Street, Bishop.
Secretary, J. Lloyd Mason, 135 East Line Street, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. M. Nicholson, Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, G. R. Fortson,* Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, E. Vincent Askey, 2210 W. Third Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles*

Marin County Medical Society
President, Rodney B. Hartman, 38 Bigelow, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, John H. Lloyd, Fort Bragg.
Secretary, Louise E. Petty, Talmage.
Meeting, *On Call.*

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Rollin Reeves, 32 E. San Luis Street, Salinas.
Secretary, S. Condit Glasgow, 8 E. Alisal Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth,* Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, D. A. Harwood,* 2145 Walnut, Santa Ana.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Edward S. Babcock, 1127 Eleventh Street, Sacramento.
Secretary, Carl E. Burkland, 510 Medico-Dental Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.*
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
President, W. Don Rolph, 640 National Avenue, National City.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Sidney J. Shipman, 490 Post Street, San Francisco.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Curtis M. Galt, 134 N. Lincoln Avenue, Manteca.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. F. Ragsdale, 717 Twelfth Street, Paso Robles.
Secretary, Harrison Eilers, Box 360, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, William A. Key, 23 Second Avenue, San Mateo.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, J. Irving Beattie,* 652 E. Santa Clara Street, San Jose.
Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
President, F. P. Shenk, Medico-Dental Building, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President*

Shasta County Medical Society
President, Oscar Jess Hansen, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Clifford M. Carlson, 576 B Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, 107 Crescent Road, San Anselmo.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, Frank L. Doane, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, G. C. Coffey, Bank of America Building, Ventura.
Secretary, M. M. Raines, 34 North Ash Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Ray E. Nichols, Woodland.
Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, John W. Lindstrum, 423 Fourth Street, Marysville.
Secretary, Joseph J. Salopek, 423 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

(Roster lists continued on advertising page 6)

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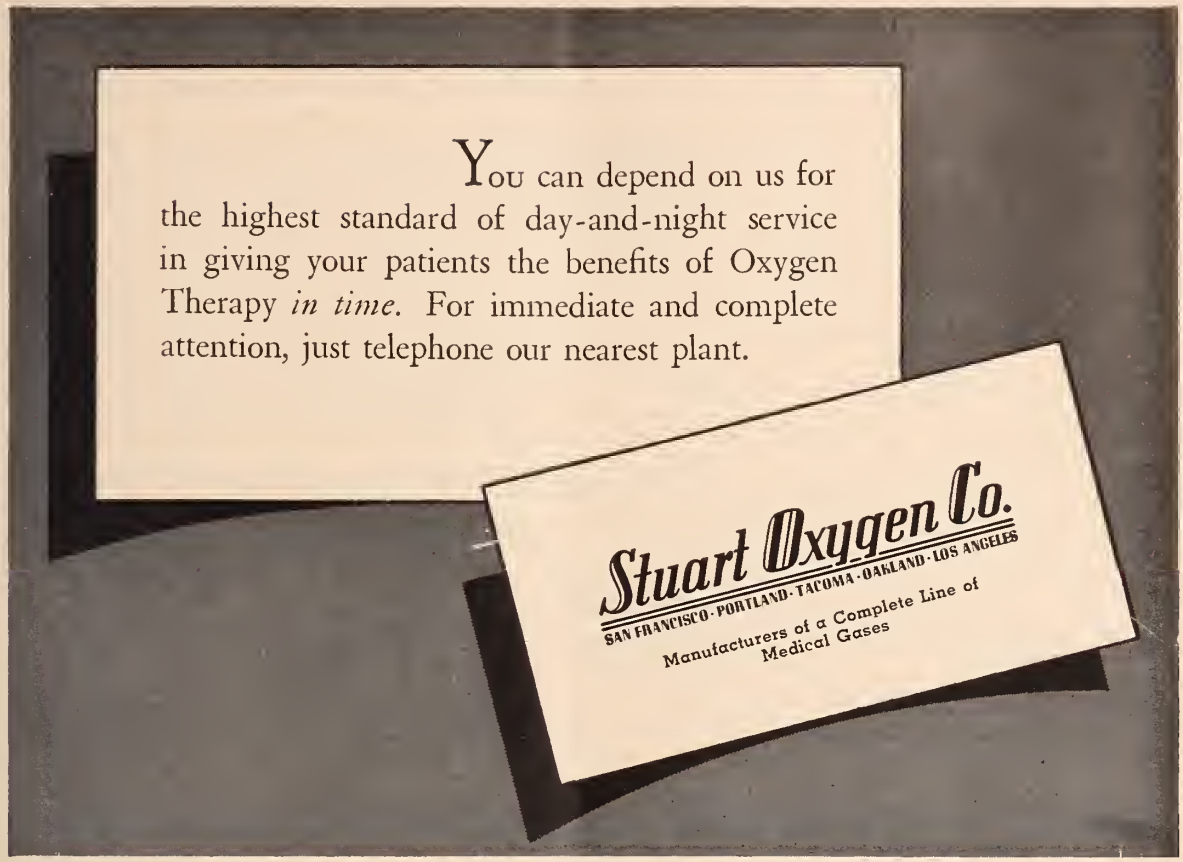
* Deceased.



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California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco. Phone WEst 8000.

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San Francisco—603 Phelan Building, 760 Market Street, San Francisco; UNderhill 8700.

Sacramento—631 J Street.

Los Angeles — State Office Building, 217 West First Street, MAdison 1281.

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Director, Wilton L. Halverson, 603 Phelan Building, 760 Market Street, San Francisco.

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Board of Medical Examiners of the State of California

San Francisco—Room 214, 515 Van Ness Avenue.

Los Angeles—906 State Building.

Sacramento — Business and Professional Building, 1020 N Street.

Secretary, Frederick N. Scatena, M. D., 1127 Eleventh Street, Sacramento.

Southern California Medical Association

President, Ray B. McCarty, 3116 Main Street, Riverside.

Secretary, Nelson Paul Anderson, 2007 Wilshire Boulevard, Los Angeles.

The Public Health League of California

Executive Secretary, Ben H. Read. San Francisco office, 251 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 5711.

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Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean.
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An Introduction to Medical Mycology. By George M. Lewis, M. D., Member of the American Dermatological Association, Inc.; Fellow of the American College of Physicians, of the American Medical Association and of the New York Academy of Medicine; Member of the New York Dermatological Society and of the Manhattan Dermatological Society; Associate Attending Physician (Dermatology), The New York Hospital; Assistant Professor of Clinical Medicine (Dermatology), Cornell University Medical School; Attending Dermatologist to St. Clare's Hospital; Visiting Dermatologist to Welfare Hospital, etc.; and Mary E. Hopper, M. S., Research Fellow in Medicine, Cornell University Medical School. Cloth. Price, $6.50. Pp. 342, illustrated. Chicago: The Year Book Publishers, Inc., 1943.

The Mind of the Injured Man. By Joseph L. Fetterman, M. A., M. D.. Assistant Clinical Professor of Nervous Diseases, Western Reserve University School of Medicine, Cleveland, Ohio. Cloth. Price, $4. Pp. 260, with 28 illustrations. Chicago: Industrial Medicine Book Company, 1943.

War Endocrinology. By James H. Hutton, M. D., Chicago, Illinois. Cloth. Pp. 363. Chicago: Privately printed by The Wayside Press, 1943.

BOOK REVIEWS

An Introduction to Medical Mycology. By George M. Lewis, M. D., Member of the American Dermatological Association, Inc.; Fellow of the American College of Psysicians, of the American Medical Association and of the New York Academy of Medicine; Member of the New York

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An entire generation of physicians lost touch with the medical lore of wine in the United States following the first World War. Actually, however, few other substances have been as widely recommended. This monograph, which summarizes the pertinent scientific literature in the interest that fact be separated from folklore by the application of impartial analysis, will prove of interest and value to specialists in many fields, and to the general practitioner as well.

A section on wine as a food is included. The actions of wine on the gastro-intestinal system, the cardio-vascular system, the genito-urinary system, the nervous system and the muscles, and the respiratory system are discussed. The uses of wine in diabetes mellitus, in acute infectious diseases and in treatment of the aged and convalescent are dealt with. There is a section on the value of wine as a vehicle for medication. Also an important section on the contraindications to the use of wine. Those who wish to pursue the subject further will find an extensive bibliography.

This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

Members of the medical profession are invited to write for this monograph. Requests should be made to the Wine Advisory Board, 85 Second Street, San Francisco.

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BOOK REVIEWS

(Continued from Page 7)

Dermatological Society and of the Manhattan Dermatological Society; Associate Attending Physician (Dermatology), The New York Hospital; Assistant Professor of Clinical Medicine (Dermatology), Cornell University Medical School; Attending Dermatologist to St. Clare's Hospital; Visiting Dermatologist to Welfare Hospital, etc.; and Mary E. Hopper, M. S., Research Fellow in Medicine, Cornell University Medical School. Cloth. Price, $6.50. Pp. 342, illustrated. Chicago: The Year Book Publishers, Inc., 1943.

This monograph is an outgrowth of lectures, talks, and discussions on mycology with postgraduate students in dermatology during the past ten years; it is based on correlation of the opinions of others with the author's experience in the laboratory and in the clinic.

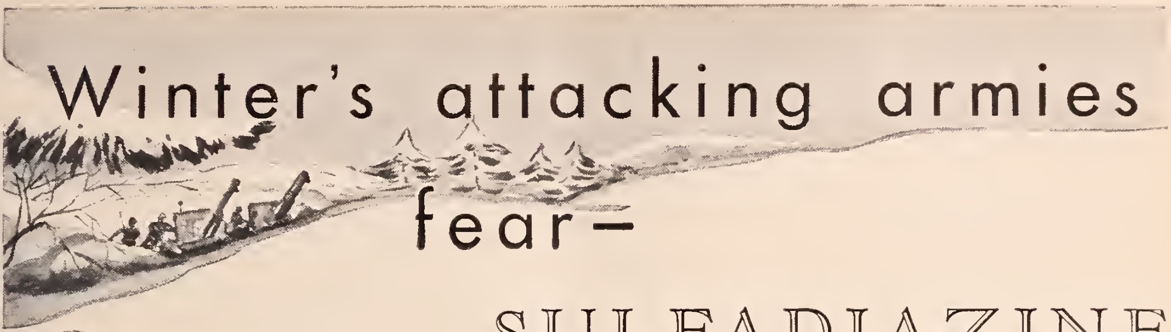
The contents are divided into two parts. The first deals with the clinical, theoretic, and experimental aspects of the subject; the second outlines the laboratory procedures useful in examining a patient suspected of having one of the various mycoses.

The functions of the mycologic laboratory are (1) to ascertain that a fungous disease exists, (2) to diagnose its type, and (3) to determine the immunologic response of the patient to the infection.

Fungous disease has been found important as a disabling factor in the armed forces. The strenuous activities of the troops, with trauma, unusual perspiration and, particularly, conditions of poor hygiene, have favored the spread of dermatophytosis, frequently changing a latent infection into a disabling one, often requiring hospitalization.

The Mind of the Injured Man. By Joseph L. Fetterman, M. A., M. D., Assistant Clinical Professor of Nervous Diseases, Western Reserve University School of Medicine,

(Continued on Page 14)



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WANTED—Association with group, partnership, industrial surgery, by surgeon, F. A. C. S., gentile; many years surgical experience on metropolitan hospital staffs; prefer California or Washington. Address: Box 9070, California and Western Medicine.

Rheumatic Fever in Children—Its Recognition and Management.—This is a 32-page clinical handbook written for the practicing physician, just released by the Metropolitan Life Insurance Company. It assembles under one cover the modern concepts of the disease; its nature, diagnosis and prognosis and the individual and community problems involved in the care of the patients. A group of distinguished clinicians and the following organizations assisted in its preparation: The American Heart Association, the American Academy of Pediatrics, the Children's Bureau of the U. S. Department of Labor, and the United States Public Health Service. Other educational material has been developed by the Company in connection with its national program to reach the general public and the medical profession with information on this disease. Single copies of the handbook are being made available to physicians without charge. Physicians who wish a copy should write to Dr. W. P. Shepard, Assistant Secretary, Metropolitan Life Insurance Company, 600 Stockton Street, San Francisco, California.

Continuous Caudal Analgesia in Obstetrics.—Eli Lilly and Company, Indianapolis, announces the release of a 16-mm. silent motion picture in color on the subject, "Continuous Caudal Analgesia in Obstetrics." The film is available to physicians for showing before medical societies and hospital staffs. It deals with the history, anatomy, and physiology of caudal analgesia and demonstrates the technique of use in obstetrics.

The film was made at the U. S. Marine Hospital, Staten Island, New York, by authorization of the Surgeon-General, U. S. Public Health Service, and the demonstrations were carried out by the originators of the technique, Dr. Robert A. Hingson and Dr. Waldo B. Edwards.

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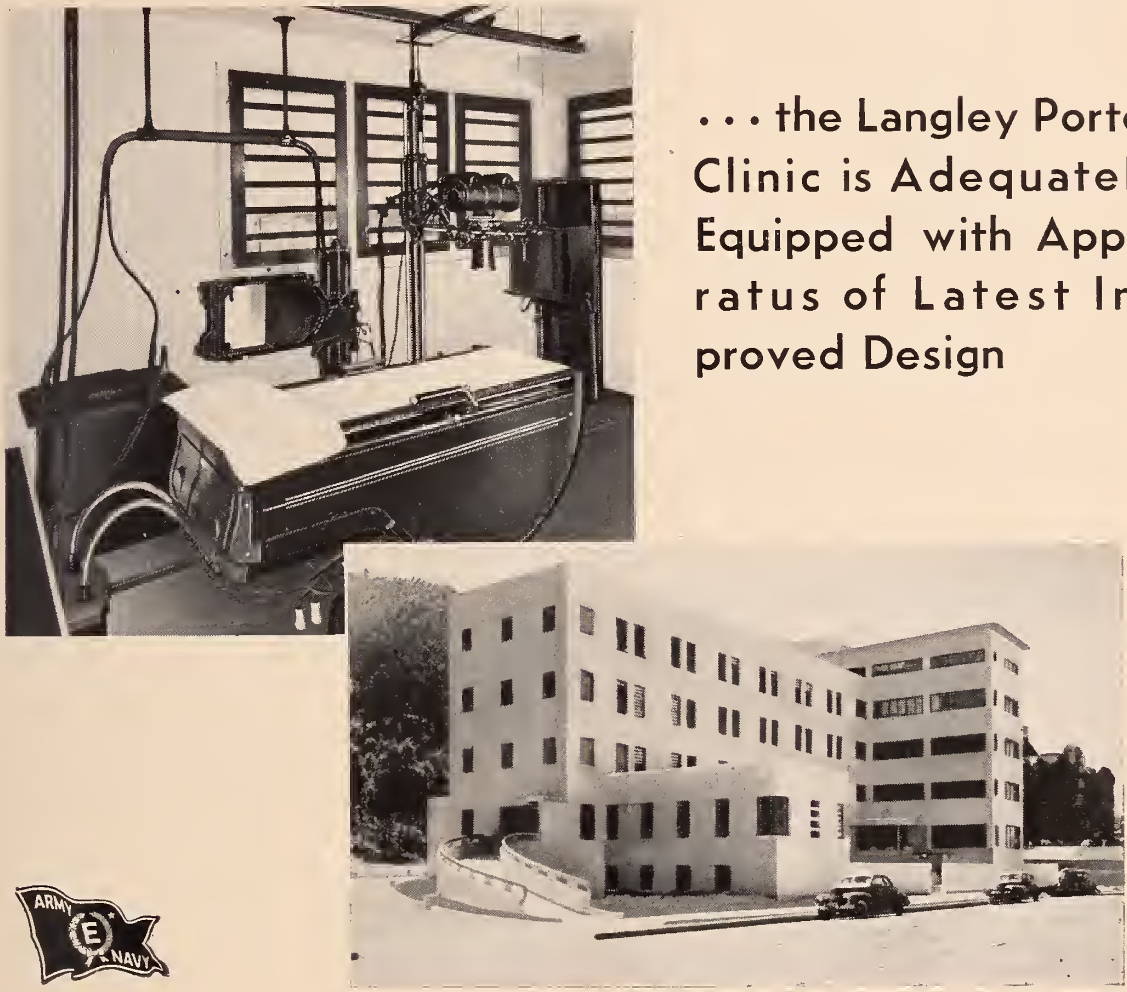

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6th Edition

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Professor of Tropical Medicine, Emeritus, Harvard University

This book presents an authoritative and practical account of tropical diseases, their clinical manifestations, diagnosis and latest methods of treatment. It discusses the zoological aspects and laboratory procedures of importance and gives attention to health problems relating to the prevention of infectious diseases. An up-to-date study of cosmopolitan diseases encountered in warm countries and of diseases of tropical origin that may become endemic in temperate climates is included.

New Orleans Medical and Surgical Journal says: "These volumes contain the most modern and comprehensive discussion of tropical medicine in English."

398 Illus. Tables. 1827 Pages. 2 Volumes $21.00 (1942)

The Blakiston Company, 1012 Walnut St., Philadelphia 5

BOOK REVIEWS

(Continued from Page 10)

Cleveland, Ohio. Cloth. Price, $4. Pp. 260, with 28 illustrations. Chicago: Industrial Medicine Book Company, 1943.

Here is a deep tale, simply told. It must needs deal in versatile fashion, with many different aspects of medicine. Men of our neurological trade would seem to be the only remaining general practitioners; our interests, and to a considerable extent our knowledge, must embrace the senses of smell, taste, hearing, touch, vision, speech; the appraisal of muscular power and the poised direction of muscular effort.

The author, too, has weighed well the rôle of coincidence in the allegation that injury, major and often minor, can precipitate long-distance and far-reaching chronic results.

War Endocrinology. By James H. Hutton, M. D., Chicago, Illinois. Cloth. Pp. 363. Chicago: Privately printed by The Wayside Press, 1943.

Endocrinology is one of several of the comparatively recent additions to medical specialties which greatly confuse the average physician. There is need not only for the specialist in this important field, but also for the practitioner to be more thoroughly informed as to the functions of the endocrines and their disorders.

The author states the book was written for the physician in private practice who lacks time or facilities to familiarize himself with the voluminous literature on endocrinology and who sees endocrinopathies as only one of his daily problems. It attempts to cull from the literature the relatively few facts of clinical importance and to present them in such a way that the busy practitioner can grasp them in the brief time his work allows for reading.

This is not a complete text on endocrinology; it will have no value to the endocrinologist. Rather it is a summation of answers to questions asked of the author at medical meetings and in correspondence. It has no review of the literature, few references to the work of hundreds of research workers who have advanced endocrinology, few statistics, no illustrations, and no bibliography.

A Family of Thirty Million. The Story of the Metropolitan Life Insurance Company. By Louis I. Dublin, Ph. D., Third Vice-President and Statistician. Cloth. Pp. 496. New York: Metropolitan Life Insurance Company, 1943.

This volume has been prepared in celebration of the seventy-fifth anniversary of the Metropolitan Life Insurance Company. It is fitting that this milestone in the life of a business institution which has become so widely known on this continent be marked by a record of events and accomplishments over the years.

At this time in our history, when the desire for security is greater than ever before, it is hoped that this volume will reflect what the American people have done through life insurance to provide financial protection for themselves. They have achieved this security to a greater degree than any other people, achieved it voluntarily, and through institutions of their own making. This is in the American tradition. They have not depended upon Government subsidy, but have themselves taken the initiative. Americans apparently prefer this method, which takes into account individual needs and relies on the sense of obligation of the head of the family to look after his own.

Today fully one-half the people of the United States and Canada depend in large measure upon the institution of life insurance for their program of family security. Nor is there any suggestion that the saturation point for the private companies has been reached. There are still many uninsured or inadequately insured individuals in the country who are the policyholders of the future.

(Continued on Page 16)

"Till He Comes Marching Home"

THE lonely lad sleeping in a foxhole remembers Mother as she was when he choked back the lump in his throat to kiss her goodbye for the last time. He does not realize that she may change, physically and psychically. To him she remains the same . . . always.

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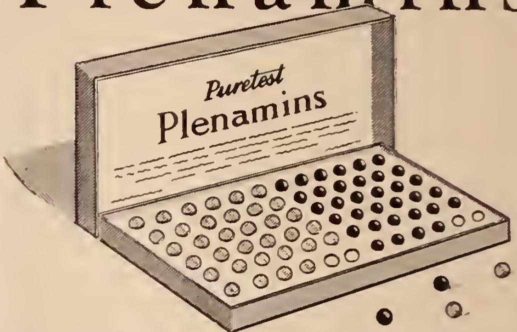

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BOOK REVIEWS

(Continued from Page 14)

Applied Anatomy of the Head and Neck. For Students and Practitioners of Dentistry. By Harry H. Shapiro, D. M. D., Assistant Professor of Anatomy, College of Physicians and Surgeons, Columbia University. Cloth. Price, $5.50. Pp. 189, with 173 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

This book is specifically designed to relate the anatomy of the head and neck to the various fields of dentistry. The anatomic detail selected for description has been confined to those features which are of the most practical significance in diagnosis and treatment. Interwoven in this description are references selected from practice. A discussion of the structures affected in maxillo-facial war injuries is included, and attention is called to the rôle of the dentist in the care of these injuries in coöperation with the plastic surgeon and the general surgeon. War casualties will demand these combined services far into the post-war period. An expanded program of dental care for civilians may also be anticipated after the war.

Methods of Treatment. By Logan Clendening, M. D., Clinical Professor of Medicine, Medical Department of the University of Kansas; Attending Physician, University of Kansas Hospitals; and Edward H. Hashinger, A. B., M. D., Clinical Professor of Medicine, Medical Department of the University of Kansas; Attending Physician, University of Kansas Hospitals; Attending Physician, St. Luke's Hospital, Kansas City, Mo. With Chapters on Special Subjects by J. B. Cowherd, M. D.; Leland F. Glaser, M. D.; Thomas B. Hall, M. D.; John S. Knight, M. D.; H. P. Kuhn, M. D.; Paul H. Lorhan, M. D.; F. C. Neff, M. D.; Don Carlos Peete, M. D.; Carl O. Rickter, M. G.; E. H. Skinner, M. D.; O. R. Withers, M. D.; and Lawrence E. Wood, M. D. Eighth Edition. Cloth. Price, $10. Pp. 1033. St. Louis: The C. V. Mosby Company, 1943.

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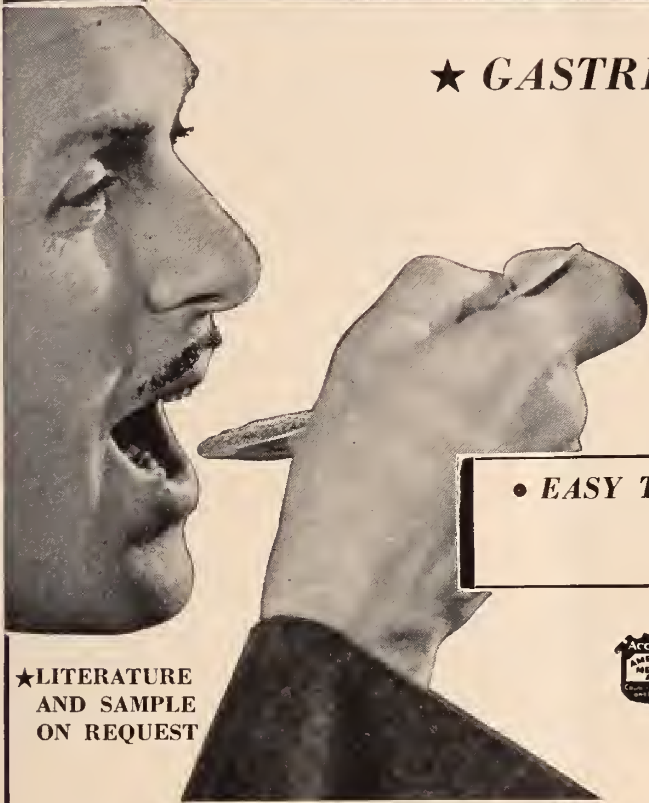

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BOOK REVIEWS

(Continued from Page 16)

This book is planned to furnish an outline of all the methods of treatment in internal medicine.

Its design contemplates gathering together material otherwise widely scattered in medical literature; as, for instance, descriptions of the technique of spinal puncture, blood transfusion, the wet pack, and the ketogenic diet.

The first part describes each procedure under the heading of drugs, diet, hydrotherapy, etc. The second considers the application, the results to be expected, etc., under the heading of the various diseases.

The Genealogy of Gynaecology. History of the Development of Gynaecology Throughout the Ages. 2000 B. C.-1800 A. D. With excerpts from the many authors who have contributed to the various phases of the subject. By James V. Ricci, A. B., M. D., Associate Clinical Professor of Gynaecology and Obstetrics, New York Medical College; Director of Gynaecology of the City Hospital, New York; Associate Attending Gynaecologist and Obstetrician, Flower and Fifth Avenue Hospitals, New York; Consultant in Gynaecology and Obstetrics, Broad Street Hospital; Fellow of the New York Academy of Medicine. Department of Gynaecology and Obstetrics of the City Hospital, New York. Cloth. Price, $8.50. Pp. 578, with illustrations. Philadelphia: The Blakiston Company, 1943.

In a great measure the development of gynecology runs a parallel course with general medicine.

Some of the great physicians of antiquity, though their field of medical activity was all-inclusive, wrote separate

(Continued on Page 18)

Quality carries on
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Drink
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Delicious and Refreshing

BOOK REVIEWS

(Continued from Page 17)

treatises on diseases peculiar to woman. Gynecology, like obstetrics, assumed a leading rôle among the ancients.

Some of the gynecological concepts, including those which prevailed during the period of medieval stagnation, when the Hippocratic tradition was entirely lost and medicine fell upon dark days, are quite amusing, not to say grotesque!

The author has followed the accepted epochal divisions of the history of medicine.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 252)

War Industries Board, and the Food, Fuel, and Railroad Administrations. Its chairman is Felix Frankfurter, Assistant to the Secretary of Labor.) . . .

The Health Officer and the War.—It is said to take nine men working "over here" to keep one soldier fighting "over there." Clearly, therefore, it is wise to keep the nine workers husky and working as well as the one soldier.

Which health officer should stay at home and who should go to war? How is the nation bearing up under the war strain? What are the special war-time health menaces of the civil population, and what are we going to do about them? What headway are we making against the venereal diseases? These are the questions to be considered at the convention of United States and Canadian sanitarians at Chicago, October 14-17, 1918, to be held under the auspices of the American Public Health Association. . . .

Urgent Need for Nurses.—Surgeon-General Gorgas has called for one thousand graduate nurses a week. Twenty-five thousand graduate nurses must be in war service by January 1, 1919—in the Army Nurse Corps, in the Navy Nurse Corps, in the United States Public Health Service, and in Red Cross war nursing. This involves withdrawal of many nurses from civilian practice and necessitates strict economy in the use of all who remain in their own communities. You can help get these nurses for our sick and wounded men by bringing this need to the attention of nurses. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Dental Initiative," by Dean Guy S. Millberry, University of California College of Dentistry, San Francisco.—At periodic intervals the people of our commonwealth are asked to decide, by ballot, questions of general and individual interest. Prior to 1910 these questions were presented in the legislative halls, referred to committees for consideration and public hearing and decided by the representatives of the people. Since 1910 we have reserved unto ourselves the right to enact legislation directly by means of the initiative, referendum, and recall.

This method, found to possess a power which would yield a great good, has also been found to possess the means of promoting selfish individual interests for those who, if willing to spend the necessary money, may bring an issue before the people.

That the initiative was never intended for these latter purposes, no one will deny. That it is being used for such purposes is apparent in an analysis of the proposed dental

(Continued on Page 20)

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

initiative amendments and the arguments favoring their adoption.

The issue is known as Initiative Amendment No. 21, or the dental measure. A synopsis of the amendments together with an analysis of them follows. . . .

From an Article on "Intestinal Obstruction, With Report of a Case Occurring in a Geophagist," by Herbert A. Johnston, M. D., Anaheim, California.—Any part of the intestinal tract may become obstructed and the condition may be termed acute, chronic, or chronic becoming acute. Since it is not purposed in this paper to deal with the incomplete, or chronic varieties, we shall consider only the acute forms of the disease. In this class we find the cases where early diagnosis and prompt relief are paramount to the preservation of the life of the patient. . . .

From an Article on "A Plea for Better Coöperation Between Physicians and Dentists," by C. H. Wake, D. D. S., Los Angeles.—Those who shoulder the burden of responsibility in the present world struggle are subject to more or less criticism. But after the hysterical stage has subsided and the criticism is based on a desire for truth and justice, then such criticism becomes constructive and not destructive. Just so is the purpose of the criticism which is to follow.

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(Continued on Page 24)

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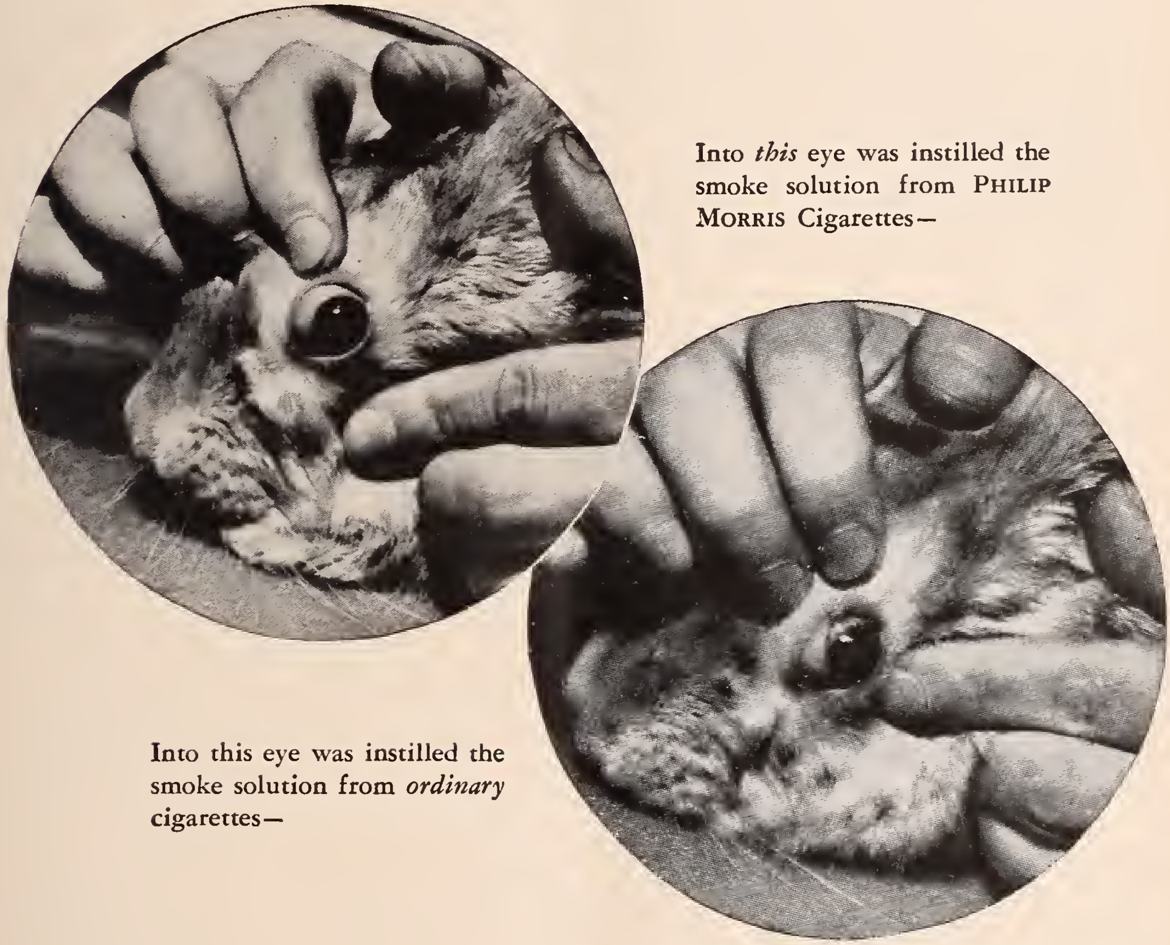

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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

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Excerpts from Correspondence: Concerning Physicians and Surgeons College, San Francisco.

San Francisco, Cal., August 24, 1918.

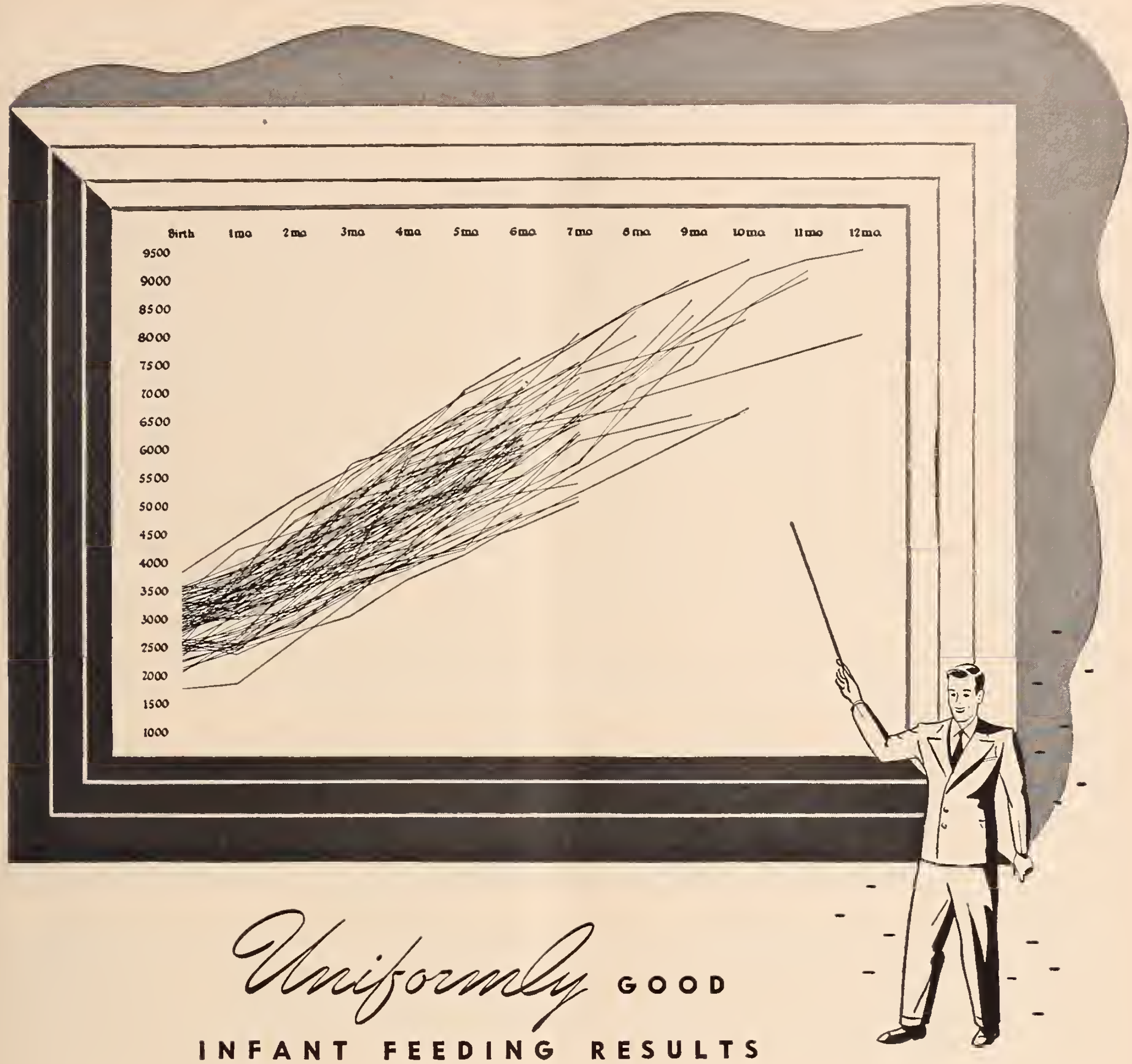
To the Editor:

I have been asked by some of the alumni of the College of Physicians and Surgeons of San Francisco, inasmuch as incorrect rumors are in circulation, to publish a brief statement of the present position of the Medical Department of that institution. In January of this year, I was requested by the Alumni Association and the Board of Trustees to undertake the reorganization of the Medical Department in accordance with the requirements of the State Board of Medical Examiners. . . .

H. D'ARCY POWER,
Dean, College of Physicians and Surgeons.

From an Article on "Reporting of Epidemic Diseases," by William C. Hassler, M. D., Health Officer.—A Request to the Physicians of San Francisco: The Board of Health of San Francisco calls the attention of all physicians of this city to the fact that "influenza," and its chief complication, "pneumonia," are reportable diseases, and asks an earnest coöperation at this time not only because the law requires the reporting of these diseases, but in so doing a large measure of protection is afforded the civil population.

(Continued in Back Advertising Section, Page 28)



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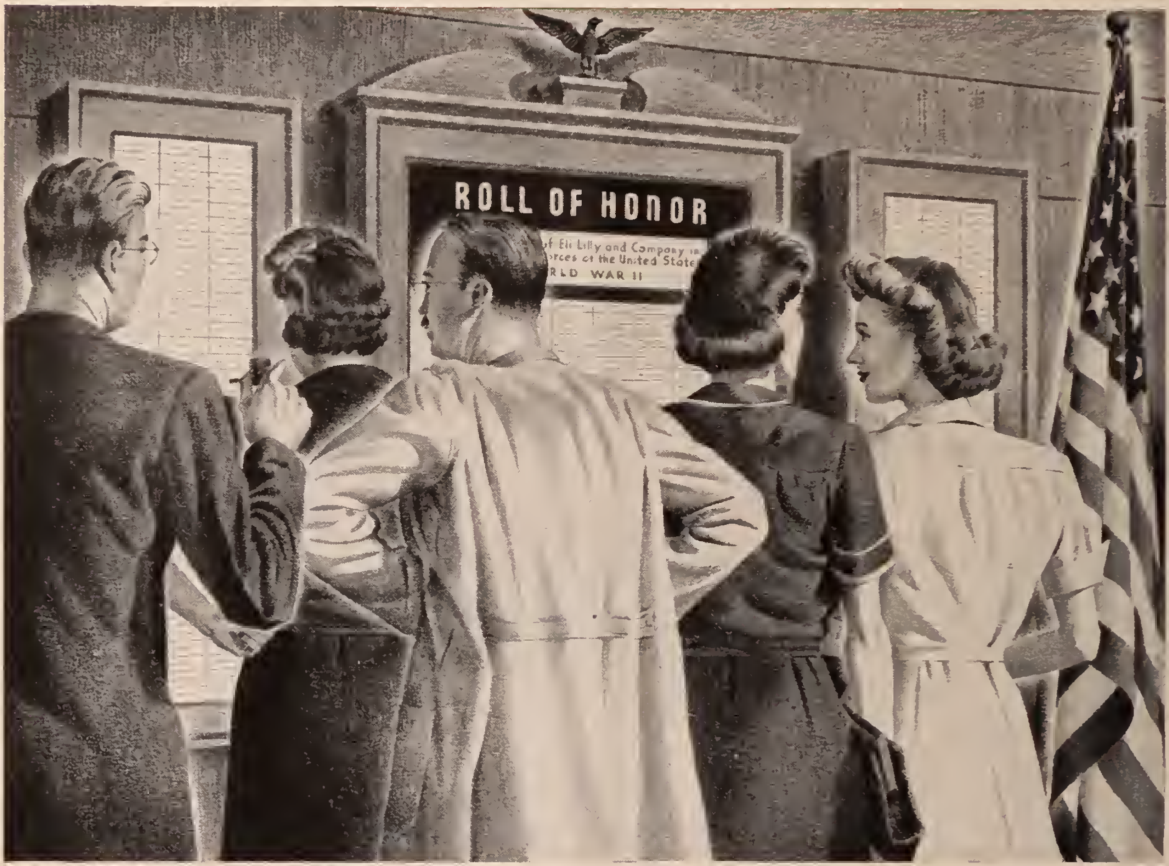
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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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EDITOR . . . . GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C. M. A. department, see index below.)

Committee on Publications

F. Burton Jones	Vallejo	1944
Francis E. Toomey	San Diego	1945
George W. Walker (Chairman)	Fresno	1946

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Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Advertising Representative for Northern California
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Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

CALIFORNIA PHYSICIANS' SERVICE AND FEDERAL HOUSING PROJECTS IN CALIFORNIA

Professional Members Have Been the Underwriters of California Physicians' Service.—More than five thousand members of the California Medical Association voluntarily joined California Physicians' Service as professional members, in order to promote the state-wide medical service that was brought into being by the California Medical Association. These professional members are the financial backers, or underwriters, of California Physicians' Service since, as professional members, they agree to render medical and surgical services on a nominal unit fee-schedule basis—which at the end of four years has not yet come up to 100 per cent of the initial unit values.

It is not necessary to discuss why such is the case, because the monthly reports and other comments which have appeared in CALIFORNIA AND WESTERN MEDICINE have given information thereon. It is to the credit of California Physicians' Service that some of its troubles have resulted from the well-meant effort to give the fullest amount of medical service.

* * *

California Physicians' Service Has Coöperated With the Government.—In line with its basic intention to be of service to California, California Physicians' Service has endeavored to coöperate with governmental agencies. Therefore, when thousands of workers gravitated to the war-industry centers such as the San Diego and the San Francisco Bay regions, it was natural for the governmental authorities to turn to California Physicians' Service and make request for a plan that would provide adequate medical care for the families of war workers.

The story of what subsequently transpired in some of the housing centers has been outlined in the OFFICIAL JOURNAL (August Calif. and West. Med., on pp. 142-144; September, pp. 193-195).

At its 312th meeting, held on August 22, the California Medical Association Council gave earnest consideration to the complications which had arisen (CALIFORNIA AND WESTERN MEDICINE, September, pp. 171-172), and which had made it necessary for California Physicians' Service to notify the Federal Public Housing Authority that on September 30, 1943, it would be obliged to terminate its contracts. The reason for the action was due to the fact that the professional members of California Physicians' Service who had been rendering professional services in the housing projects—upon the basis of the nominal fee schedule adopted—had given medical care during the period September, 1942 to May, 1943, amounting to a total of $365,000, whereas the total received from the housing-center tenants amounted to only $241,000, approximating an average monthly loss to California Physicians' Service in excess of $12,000. Members who desire a clear understanding of the situation should read the items referred to.

Representatives of California Physicians' Service and the California Housing Authorities found it necessary to journey to Washington to place the problems before the federal officials in the effort to provide care for the housing tenants. As stated, the original contracts were abrogated on September 30, 1943. However, the medical service is being continued by California Physicians' Service under an emergency arrangement with the federal authorities, wherein lesser coverage is granted. Additional information concerning this is given in the California Physicians' Service department in this issue. It is to be hoped that satisfactory solutions of a permanent nature will be brought into being.

MATERNITY AND PEDIATRIC PLAN OF THE FEDERAL CHILDREN'S BUREAU

Payment Plan of Children's Bureau Objectionable.—Commencing in the June issue, editorial and other comment on the maternity-pediatric plan of the Children's Bureau of the United States Department of Labor has appeared in each issue of California and Western Medicine. (References: June issue, on p. 314; July, pp. 1 and 79-88; August, pp. 105 and 133; September, pp. 156 and 178-182.)

The objectives contemplated in the federal appropriations to be made through grants-in-aid to state boards of health, for the purpose of providing adequate obstetric, pediatric, hospital and nursing care for the wives and infants of enlisted men in the armed forces, is one with which the medical profession everywhere has been and is in full accord.

Not so, however, as regards the methods of payment for medical services to be rendered to these patients, as designed and promulgated by the authorities of the Federal Children's Bureau in Washington, D. C. In some of the references given above, attention is called to deficiencies in the plan proposed by the Children's Bureau and to resolutions by national and state medical societies in which request is made that proposed fee schedules for professional services shall provide that the monies paid through a state board of health shall be made direct to the wife, and not to the attending physician; the patient to make her own financial arrangements with her attending physician.

* * *

The Menace of the Arbitrary Fee Schedule.—The Federal Children's Bureau, however, contends it can make no such arrangements. If the Bureau's decision stands, it means that an arbitrary fee schedule for obstetric-pediatric care, averaging somewhere between $35 and $50 will become operative from one end of the United States to the other, to apply to the wives of enlisted men. The significance of this rests on the fact that the armed services may include more than ten million enlisted men.

Now it is not possible to say when the present global war will end. In the meantime, the below-cost schedules of $35 to $50 to cover prenatal, confinement and postpartum care will become firmly established in the minds of hundreds of thousands of American citizens. Consequently, in the postwar period, fees in excess of the below-cost schedules of $35 and $50 will be looked upon by many citizens as extortion or something worse. Not a pleasant reaction for physicians to anticipate.

Under existing conditions, with the great demands now made upon the time and services of members of the medical profession, it is held by many physicians and others that the quality of obstetric-pediatric service under the plan inaugurated by the Federal Children's Bureau will not measure up to the best standards of the past. If such be the result, the supposed aid to the wives and infants of enlisted men will not be the generous gesture outlined in the basic objective. Further light is shed on this in articles to be found on pages 227-228.

* * *

Concerning Additional Payments by Patients.—In California and Western Medicine for July, under Item VI on page 81, appeared the maternity-pediatric resolution adopted by the Council of the California Medical Association, and under Item XI on page 83, the letter sent to the component county medical societies. Attention is called to the second-last paragraph of the letter of July 1, 1943. A correction was made as given in the later Council proceedings (September California and Western Medicine, on page 171). To prevent misunderstanding, the present procedure of the California State Board of Public Health appears below:

"Attention was called to the statement received from the California State Board of Health that, when a physician contracted to accept obstetric or pediatric work under the Federal Children's Bureau plan, the physician under the regulations put forth by the Children's Bureau of the United States Department of Labor is not permitted to accept the payment from the California State Board of Public Health—acting for the Federal Children's Bureau—and also accept an additional payment from the patient *for the same service*. However, for services to mother or child that are not included in the authorized schedules of the Children's Bureau, payments therefor may be made by the patient."

Additional information concerning the maternity-pediatric program and resolutions adopted by some of the component county medical societies in California appears in the current issue (Items XXIV-XXX, on pages 226-230).

Because the plan of the Federal Children's Bureau has such broad implications in relation to present and future medical practice, it will be of interest to note how its administration will work out in actual practice in the months ahead.

AN AUTHOR, de KRUIF, FINDS IN CALIFORNIA THE SOLUTION OF FUTURE MEDICAL PRACTICE!

Comments on a Book Review.—Last month California and Western Medicine received for review a copy of the book, "Kaiser Wakes the Doctors," by Paul de Kruif. Comment is here made on the volume because the author, as a result of visits to the Kaiser shipyards in the San Francisco Bay region, has persuaded or entranced himself into proposing that the solution of the problem of providing adequate medical care for all classes of citizens is to be found in the medical service arrangements that have been set up in the shipyards located in Richmond, California, at Vancouver, Washington, and other places where Mr. Henry Kaiser and associates have installed their wartime industries.

In the description of the plans he discusses, de Kruif makes more than generous use of superlative adjectives, the three personages who receive most of his superpraises being: the director of the shipyards, Mr. Kaiser; its medical supervisor, Doctor Garfield; and the author himself, Mr. Paul de Kruif.

If the plan of medical service as it is being operated in the enterprises of the Kaiser interests possessed all the merits so enthusiastically portrayed by de Kruif, and if the procedures propagandized by him were new and particularly could be used in urban and rural districts of California and other states where altogether different conditions exist, then the laudations so generously bestowed upon Messrs. Kaiser, Garfield, and de Kruif might not only be justified but perhaps might even be accepted by the medical profession, which is the one group of citizens whose members have the most direct and intimate knowledge of the medical care problems which the book attempts to discuss.

* * *

Excerpts in This Issue.—In this number,* excerpts from de Kruif's opus, with comments thereon, are presented for the convenience of readers who may be reluctant to pay two dollars for the opportunity to read his cure-all exposition or advocacy of the millenium in medical service—at least until they have first assured themselves that the expenditure involved will be justified. Members of the State Association should take the time to scan the items referred to, since the story largely revolves around plans now in operation in California. After perusal of the excerpts and comments, readers may more easily decide whether they wish to embark upon the financial outlay involved in purchase of the author's effort as given in some 158 pages of text.

Author's Analogy Is Faulty.—In the volume, de Kruif as analogist†, outlines the plans of the Permanente Foundation and related medical services now offered in the shipyards, where 50 cents per week is deducted from wages of each employee (there being practically no acquisition costs in securing members to the plan, certainly a great administrative saving!); the wage deductions being taken from a group of about 100,000 workers (the families, however, are not included!); the plan being in operation in enterprises where all the workers reside within a small and limited geographical area. In essence, the discovery—for that is how de Kruif seems to regard it—is nothing more than an application of the age-old principle of prepayments on an insurance basis, designed to give protective coverage to a limited group of poor risks through acquisition of a large number of paying good risks.

However, when from this special instance—of an unusual and wartime condition related to a large number of workers under a single management—de Kruif proceeds to draw the general conclusion, that the same degree of medical service could be brought into being throughout almost the entire United States, not only for workers but also for their families, and in regions where the wage-earners are scattered and working for many instead of a single employer, and so forth, one is tempted to wonder in what college or school of experience de Kruif took his courses in logic. When analogies used as premises are not sound, it follows that the conclusions and recommendations made thereon are in error. Many inconsistencies in statements and reasoning are presented by de Kruif, but for these, readers are referred to the book itself; or to the excerpts in this issue, which appear on page 244.

* * *

Regrettable Results of Promulgations Such as Those of de Kruif.—In spite of its radical proposals, it is not surprising that de Kruif's book has received some complimentary review notices from lay editors, whose lack of knowledge of medical practice prevents them from discerning the fallacies to be found in the author's expositions. For example, see "Books on Parade" review, on page 249.

Unfortunately, such reviews in the public press are read by a host of citizens, many of whom are thus led into accepting erroneous concepts concerning existing medical practice.

* * *

Interesting Statements by Mr. Kaiser.—Mr. Henry Kaiser himself seems to have fallen under the spell of either de Kruif's or his own thinking, if one may judge from recent press dispatches of a speech by him, which can best speak for itself. Quotation follows:

SEVEN CENTS A DAY MEDICINE SEEN

New York, Sept. 18 (INS).—Henry J. Kaiser foresees a future in which the health of the entire American population will be safeguarded by "little Mayo clinics"—small, personalized groups in which medical and hospital care is financed through individual payment of seven cents a day, or less.

---

* See article, "Kaiser Wakes the Doctors?," on page 244.

† Oxford English Dictionary, in its definition of analogy, states "Presumptive reasoning based on the assumption that if things have similar attributes they will have other similar attributes." "Analogist, one who seeks, or argues from, analogies."

The "miracle man of shipbuilding" told the convention of disabled American Veterans about it Saturday, and later amplified his statements in an interview with reporters.

Kaiser described his seven-cents-a-day system now in operation throughout his vast network of shipyard enterprises—a plan which he originated at Grand Coulee dam four or five years ago.

Plan Boosts Efficiency

"This is prepaid health insurance," he said, "and I believe it has increased our efficiency at least 5 per cent. In one month fifty-five doctors treated 125,000 patients. We don't just wait till they send for a doctor, who tells them they're sick enough to go to a hospital. We go out and send them to the hospital.

"I believe the future will see groups of 'little Mayo clinics' in hotels, in industrial plants, among merchants, and even in rural communities. It will be a great thing for the disabled doctors who come back from the war, too. There are now 100,000 doctors in our armed forces. Many will return disabled. Many will be able to carry on their profession in these clinics, despite the handicap."—Portland *Oregonian*, September 19.

In the above press item, the general and erroneous argument of de Kruif is again expounded, but through press association dispatches, owing to the present prominence of Mr. Kaiser, it has no doubt come to the attention of thousands and thousands of citizens. It is only another example that goes to explain why so many citizens throughout the nation have been misled into forming faulty opinions concerning modern-day medicine and practice, and emphasizes again why the medical profession should carry on consistent educational campaigns in which actual facts and truths concerning medical service and practice will be presented to the public.

Readers of California and Western Medicine may find it worth while to refer to the review excerpts from de Kruif's book, printed elsewhere in this issue. Comment is there made for which no place can be found in this department of the Official Journal

WAGNER-MURRAY BILL: CRITICISM FROM AN UNSUSPECTED SOURCE

Health and Sickness Legislation in California.—The first major attempt to inflict a compulsory health insurance plan upon California was made more than twenty-five years ago. Mr. Chester Rowell of San Francisco, well-known editor and publicist, was the chairman of the State Commission in charge of the effort, and Miss Barbara Nachtrieb its secretary. A quarter of a century later they were still active in their propaganda. So much so, that Governor Olson appointed them to the same positions when, several years ago, he attempted, unsuccessfully, to drive a "must pass" compulsory health insurance measure through the California Legislature.

* * *

Columnist Rowell's Criticisms of the Wagner-Murray Bill.—Mr. Rowell, in his syndicated press column, again and again has discussed health or sickness insurance. In his comments he has not been backward in casting blame upon organized medicine and its representatives as being responsible in good part for the non-enactment of proposed statutes designed to bring sickness insurance into operation under State control.

When on September 7, 1943, he printed some sharp criticisms of the Wagner-Murray-Dingell Bill (S. 1161), his action took on interest for Californians. In this place, only brief excerpts are given, the complete article appearing in the Department of the Committee on Public Policy and Legislation, on page 233.

Somebody sends a reprint of a letter from a Chicago correspondent to the *Christian Science Monitor* quoting medical, not Christian Science, objections to an alleged "Wagner-Murray" bill said to be before Congress which, under the guise of sickness insurance, has for its real purpose the destruction of "free economy" and the "complete bureaucratic domination of the American people," and the reduction of the doctors to "abject slavery." . . .

But all this has nothing to do with the immediate publicity, which is all quoted from one John M. Pratt, "executive administrator" (in other words, publicity agent) of the "National Physicians' Committee." . . .

We have not seen the text of this alleged sickness insurance bill, but if it even remotely resembles the account of it quoted from Mr. Pratt, it could scarcely receive a single vote in Congress and would certainly be repudiated by every informed supporter of health insurance. There were no such provisions in a single health insurance system in the world in the days before the war when every civilized country except the United States had such a system, and this writer at least, who has for fifty years been urging the adoption of health insurance by American states, never heard of any such proposal here—except in the bugaboo publicity of paid lobbyists. . . .

Here, however, is one of them who, like the gentleman from Missouri, waits to be "shown."

In the above, Mr. Rowell states he was not in possession of a copy of the Wagner-Murray Bill, but he has no doubt made request therefor. After he peruses the text of S. 1161, he will probably find that the statements concerning its contents and scope, as put out by the National Physicians' Committee, are quite to the point. In view of his implied condemnation of the measure—on the basis of the N. P. S. digest—it will be interesting to observe what trend future remarks by Mr. Rowell on the Wagner-Murray-Dingell Bill (S. 1161) will take.

IN RETROSPECT: ON TWO MILITARY ITEMS

Physicians Enrolled in Armed Services in World War I.—Some readers have established the habit of scanning the items which appear in the Twenty-Five Years Ago department, to be found always on the last text page of every issue of California and Western Medicine. Because many other members may not read that column, two excerpts in the current issue appear below, which should be of interest since they shed light on the activities of the medical profession in World War I. Colleagues of twenty-five years ago set an excellent standard.

Quotations follow:

> *Fifty Thousand Medical Officers.*—With an army of three million men in the field [October, 1918] or in training and as contemplated, an expansion of this force to five million men, the Surgeon General must have in the Medical Reserve Corps at least fifty thousand doctors. The Medical Reserve Corps must keep pace in growth with the army expansion and it behooves every doctor in the United States between the ages of 21 and 55, who is physically, morally, and professionally fit, at the earliest possible moment to arrange his personal affairs so as to offer his services to his country in the capacity of a medical officer. The United States is in the war to win and this can only be accomplished by a large and well-trained body of troops adequately cared for by a sufficient number of medical officers. The importance of the doctor's service and its relation to the successful outcome of the war cannot be overestimated. . . .

* * *

> *Volunteer Medical Service Corps.*—To date [October, 1918] about 40,000 of the 144,116 doctors in the United States—not including the more than 5,000 women doctors—either are in Government service or have volunteered their services. Up to July 12 the Surgeon-General had recommended to the Adjutant-General 26,733 doctors for commission in the Medical Reserve Corps. About 9,000 others who applied were rejected. With the 1,194 in the Medical Corps of the National Guard and 1,600 in the Navy, the total—38,527—constitutes 26.73 per cent of the civilian doctors. Deducting those who declined their commissions or who have been discharged because of subsequent physical disability or other cause, the number actually commissioned in the Medical Reserve Corps stands (August 23) at 23,531 with several hundred recommended whose commissions are pending. Of the 23,531, there are 22,232 now on active duty. . . .

EDITORIAL COMMENT†

AUTOALLERGIC DERMATITIS

In 1934, Whitfield[1] introduced the term "autosensitization eczema" to explain certain puzzling dermatoses, which he believed were due to the patient's acquired sensitization to the slightly denatured organ-specific proteins of his own skin. This nomenclature offered a convenient explanation for the apparently spontaneous continuation or spread of eczematous and urticarial lesions, for the jumping about, waxing and waning of such lesions, and for their appearance at the site of minor skin irritation. The nomenclature, however, was received with skepticism by most professional immunologists since it was not based on experimental evidence that dermal proteins are organ-specific and can function as isoantigens. Proof of dermal isoantigenicity, however, is currently reported by Hecht[2] and his associates of the United States Army Medical Corps, and the Department of Dermatology, University of Illinois.

Finely minced rabbit skin was mixed with an equal volume of aluminum cream, according to the Walker[3] technique and the mixture injected into the muscles of the hindlegs of normal rabbits to form several deposits of skin material which presumably would be slowly autolysed and absorbed. Heart blood drawn at weekly intervals from the injected rabbits was titrated for antiskin precipitin; filtered rabbit skin autolysate being used as test antigen. This autolysate was prepared by 150-hour incubation of finely minced rabbit skin suspended in an equal volume of saline solution. Four rabbits thus tested showed no suggestion of specific antiskin precipitins (ring test). In two other rabbits, however, the faintest suggestion of a positive reaction was noted.

These findings are reminiscent of earlier results with homologous lens proteins, most investigators reporting only an occasional faintly positive isoantigenic reaction. It was subsequently shown,[4] however, that autogenous lens proteins could be "potentiated" or otherwise increased to full antigenicity by mixing them with staphylococcus toxin or by a simultaneous injection of lens protein and toxin. Applying this technique, Hecht injected other groups of rabbits intramuscularly with rabbit skin material, followed by repeated daily intracutaneous injections of staphylococcus filtrate. All rabbits thus injected developed relatively high titer specific antiskin precipitins. In some cases the titer reached three plus or even four plus on their precipitin scale. Rabbits injected with staphylococcus toxin alone and all untreated controls gave uniformly negative results.

Hecht found that rabbits which had thus developed antiskin precipitins manifested "special kinds of lesions" (details not given) when their skins were subjected to various kinds of trauma and irritation. Rabbits without demonstrable antiskin precipitins failed to develop these types of lesions in response to identical forms of skin trauma. The work of the Illinois dermatologists, therefore, offers belated scientific evidence for the "autosensitization eczema" or autoanaphylactic dermatitis of current clinical nomenclature.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

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Now more than at any other time, because of the pressure of work, longer hours, and crowded and unsatisfactory living conditions, there is reason for extra precaution so far as tuberculous infection is concerned, both in large and small industries. Many individuals will have to be employed whose health is substandard and who should be considered more susceptible to such infection. Therefore, there should be more effort made to extend and maintain proper health supervision, especially in regard to the detection and control of tuberculosis.—W. A. Sawyer, M. D., *New York State Journal of Medicine,* January 15, 1943.

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† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

Scientific and General

LYMPHOCYTIC HYPERPLASIA AND "SPONTANEOUS" ALIMENTARY LESIONS[*]

A. W. Meyer, M. D.
Palo Alto

In connection with his description of lymphocytic nodules,[†] Gerlach, 1854, represented "a solitary gland" of Peyer from the colon devoid of villi and covered by very low epithelium, as shown here in Figure 1.

While studying the lingual tonsil in 1882, Stöhr found the squamous epithelium "rarefied" wherever lymphatic nodules were numerous, and observed that the surface of the epithelium was covered by large masses of clumped "lymphoid cells." He said he had thought at first that these phenomena were pathological, but convinced himself to the contrary by examining similar material from freshly decapitated animals in all of which "lymphoid cells" lay singly and in masses between the epithelial cells.

In 1884 Stöhr observed what he called a massive penetration (massenhafte Durchwanderung) of the squamous epithelium over lingual and faucial tonsils, constantly present, and far from pathological. He further emphasized that although the "leukocytes"[‡] passed between the epithelial cells they undoubtedly not only affected the function of the latter by their mass migration, but also destroyed them. He accompanied his discussion by fine drawings, one of which (Figure 14, Plate X) is reproduced here as Figure 2. Stöhr especially considered the gaps thus formed in the epithelium and suggested that microörganisms could, no doubt, get in as well as "leukocytes" could get out.

In 1889, he also observed "leukocytes" between and within the epithelial cells over intestinal lymph nodules and hence felt compelled to admit an invasion of the epithelial cells by "leukocytes." Although Stöhr did not recognize it, his description of these epithelial cells suggests that this invasion was taking place only into degenerate cells.

When studying the human appendix, Rüdinger, 1891, said that the epithelium was invaded by lymphocytes, especially where a "ripe" lymphatic nodule approached its undersurface. He thought that this invasion is periodic and concluded that the resultant changes in the epithelium led to the formation of new lymphocytes. He also reported that whenever a lymphatic nodule became large, it extended beyond the boundary of the muscularis mucosae and between Lieberkühn's glands (intestinal crypts) which were pushed aside and hence took a slanting position to the follicle. He was surprised by the absence of glands over the nodules, observed degenerative changes in glands which had become surroundel by lymphocytes and emphasized that they do not disappear merely because they are pushed aside, but, like Davidoff, 1887, concluded that "leukocytes" arise from dying epithelial cells.

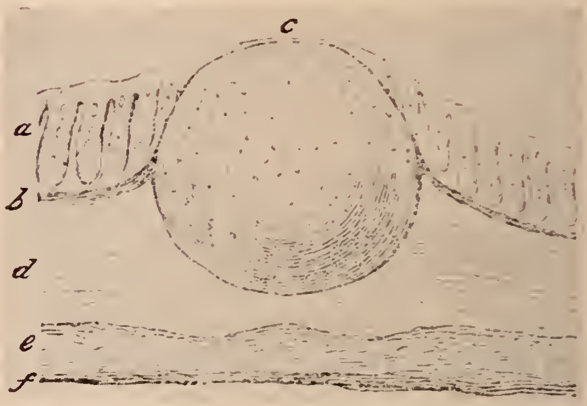

Fig. 1.—A solitary lymph nodule from the human colon after Gerlach, 1854; figure 156, showing the presence of low epithelium over the nodule. *a.* Lieberkühn's glands; *b.* muscularis mucosae; *c.* solitary lymph nodule; *d.* submucosa; *e.* muscularis; *f.* serosa X35.

It is especially noteworthy that when studying the development of the lymphatic nodules of the intestine, and the degeneration of the glands, Stöhr, 1898, found low epithelium over an appendicular nodule from a six-month-old fetus, and represented a dilated capillary very close to the undersurface of the epithelium, as represented in Figure 3.

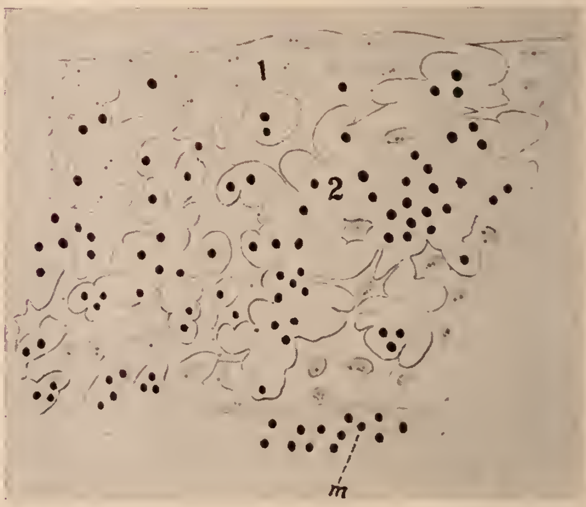

Fig. 2.—An exactly vertical section through the epithelium of a "follicular gland" from the tongue of a healthy adult male. Circa X400. The left half containing smaller and the right larger gaps in the mucosa. After Stöhr, 1884. 1. squamous surface epithelium. 2. spaces in the same made by the "leukocytes"; *m.* "leukocytes."

Von Ebner, 1899, also mentioned the absence of "glands" (crypts) over aggregate nodules and represented the epithelium without goblet cells and lower over them, in a drawing of a section taken from an appendix from a 23-year-old, beheaded individual, as represented here in Figure 4. He also represented a lymphatic nodule from the colon as having penetrated the muscularis mucosae and displaced Lieberkühn's glands, as represented in Figure 5. He found the squamous epithelium over the lymph nodules of the tongue displaced completely by leukocytes in some areas, as represented in Figure 6. A similar figure is found in the second, if not also in the first edition of the textbook of histology by Böhm and Davidoff, 1901,* and in the atlas of Sobotta, 1902 (Figure 2, Table 31). The latter found the epithelium lining a faucial, tonsillar crypt from an executed person 22 years old, in the condition represented here in Figure 7. In the legend, Sobotta stated that the basal limit of the epithelium cannot be recognized on the right, in the section, and in the second edition of this work, 1911, he again spoke of a mass passage (massenhafte Durchwanderung) of leukocytes through the epithelium. Since the Germans use the word "Einwanderung" for infiltration, it is clear that Sobotta, as Stöhr, 1884, who first used the term "Durchwanderung" in this connection, thought that great masses of leukocytes actually passed to the exterior through the epithelium, not merely into it.

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[*] From the Department of Anatomy, Stanford University.

[†] The name Balgdrüse—follicular gland—was given lymphatic nodules of the tongue through a misconception and unfortunately was retained in the B. N. A. in the form of lymph follicle. They are, to be sure, not follicles (bags), but nodules, and not lymphoid (lymph-like), or composed of lymph, but of lymphocytes.

[‡] Stöhr chose the word leukocytes in preference to lymphoid cells used in his earlier publication, because he regarded it as more noncommittal.

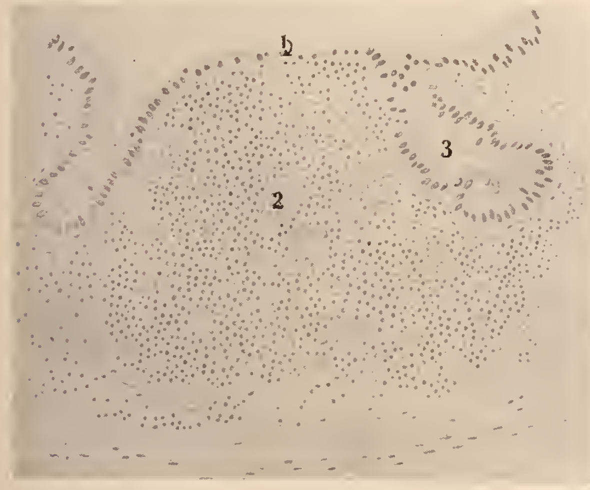

Fig. 3.—A section through an appendicular lymph nodule from a six months' fetus after Stöhr, 1898; figure 23, also showing a lower epithelium over the developing follicle. 1. epithelium; 2. lymph nodule; 3. glands of Lieberkühn; muscularis mucosae below.

AUTHOR'S OBSERVATIONS

While searching for an explanation for the very common presence of individual and multiple cysts in the pharyngeal and their practical absence in the faucial tonsils, in dissecting-room bodies, I could not help but be impressed by the striking transitions in the squamous epithelium over the surface of faucial and pharyngeal tonsils, and in their crypts, as represented in Figure 8, after Braus, 1924 (Figure 69). It will be noted that a rather sudden transition from the usual thick squamous epithelium to a mere line containing an occasional small, degenerate nucleus, is shown on the upper right, opposite, or over, a hyperplastic lymphatic nodule. Such transitions in the epithelium were common upon the surfaces as well as in the crypts of young, decidedly hyperplastic, healthy, faucial and pharyngeal tonsils removed operatively in 1928, and fixed immediately in Bouin. It is interesting, startling, in fact, that Braus regarded the resultant lymphocytic squamous epithelial mass as a "mixed lympho-epithelial organ" in which the two cell types were in symbiosis!

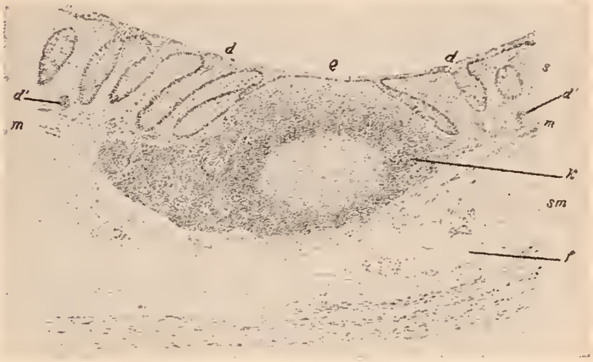

Fig. 4.—A portion of a transverse section through an appendicular lymph nodule from a 23-year-old guillotined man after von Ebner, 1899, figure 998, showing displacement of the adjacent crypts, absence of a propria, etc., and lower epithelium over the nodule. *d.* glands with goblet cells; *d*¹. sections of the ends of glands; *e.* epithelium over the solitary nodule without goblet cells. *s.* mucosa. *m.* muscularis mucosae interrupted by the nodule; *sm.* submucosa with vessels and fat cells.

Böhm and Davidoff, 1901, on the other hand, said (page 225) that "The epithelial walls of the follicular cavities often show extensive degenerative changes, which are accompanied by increased migration of leukocytes into the oral cavity," and added on the next page, "The epithelium lining the crypts or cavities of the tonsils shows, as in the lingual follicles, extensive degenerative changes, resulting mainly in the formation of variously shaped (sic), communicating spaces filled with

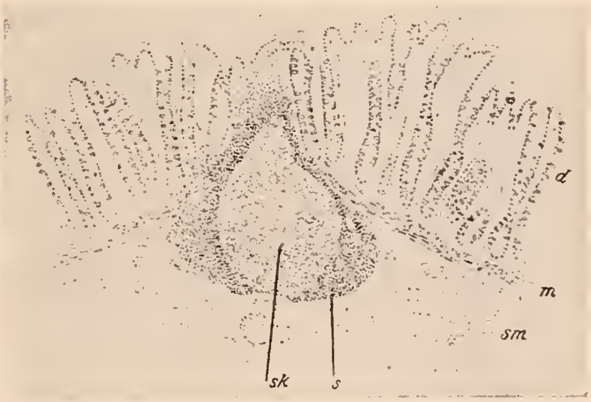

Fig. 5.—A transverse section of the colonic mucosa after von Ebner, 1899, figure 999, showing the absence of goblet cells in the epithelium over the nodule, penetration of the muscularis mucosae and extension of the lymphatic tissue to the under surface of the epithelium X35. *d.* Lieberkühn's gland, goblet cells dark; *m.* muscularis mucosae; *s.* solitary nodule; *sk.* secondary nodule; *sm.* submucosa.

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* The first edition, in German, appeared in 1895; the second in 1898.

lymphocytes and leukocytes." Stöhr, 1884, on the other hand, thought that the infiltrated lymphocytes multiplied by mitosis, and were increased in number by further infiltration to form the spaces in the epithelium he saw and represented as shown here in Figure 2.

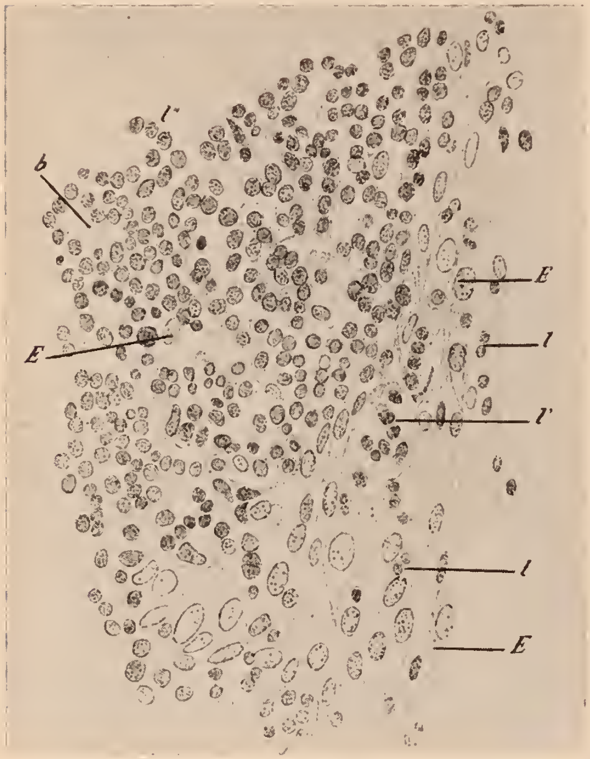

Fig. 6.—A portion of a vertical section of the epithelium from the "root" of the tongue after von Ebner, 1899, figure 898 (X500) said to show "passage" of lymphocytes through the epithelium. E=epithelium; 1, 1′ and 1″="leukocytes" which in the case of 1″ have completely pushed aside (verdrängt) the epithelium; *b*, blood vessel.

Upon further study of lymphocytic nodules of the oral cavity and the alimentary tract, I found that similar infiltration and destruction of the epithelium occurred wherever hyperplastic lymph nodules, whether isolated or aggregate, were present and that this phenomenon was especially common and probably universal in appendices not known to be or regarded as diseased. This condition, destruction of epithelium, is illustrated well by specimens in histological teaching collections and is represented in a fine drawing by Ruth Huntington, published by Kelly, 1905, of a section from an allegedly "normal appendix," a portion of which is reproduced here as Figure 9. That similar conditions are common in appendices is indicated by the studies of Aschoff, 1912 and 1930, and especially by that of Shelly, 1937, of 155 and 2,065 appendices, respectively, removed incidentally.

The absence of villi, crypts and goblet cells especially over aggregate lymph nodules has long been known, and that the last two also may disappear over hyperplastic lymphatic nodules in the appendix also was noted. Unless the crypts remained intact and gradually shortened until they disappeared, it follows that their destruction accompanying lymphatic hyperplasia must be accompanied by the production of a break, or breaks, in continuity somewhere along their tubular bodies. Moreover, marked lymphatic hyperplasia cannot occur without derangement of the architecture of the mucosa and interference with the function of the structures affected.

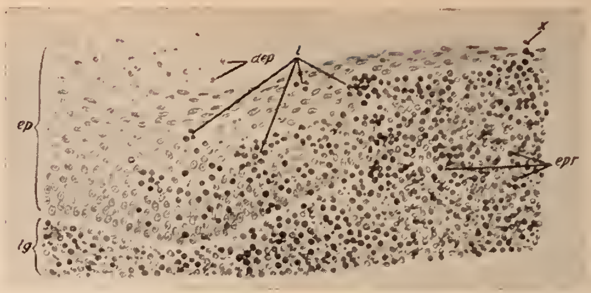

Fig. 7.—A section through a part of the mucosa of a tonsillar sulcus (Bucht) (crypt) after Sobotta, 1902, figure 2, plate 31, said to illustrate the penetration (Durchwanderung) of the epithelium by "leukocytes" until only nests of epithelial cells are left at the right where the basal limits of the epithelium are said to be unrecognizable. (X220.) d. ep., desquamated epithelium in a tonsillar sulcus; ep., epithelium; ep. r, epithelial remnants; l, leukocytes; lg, lympoid tissue of the mucosa; X, leukocytes advancing into lumen of a tonsillar crypt.

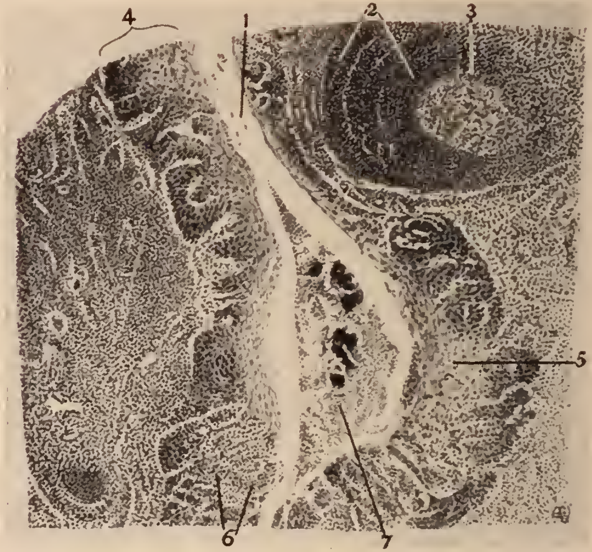

Fig. 8.—Migration of lymphocytes into epithelium of a crypt. (X68.) After Braus, 1924. Note especially the region of the nodule where the epithelium is reduced to a very thin layer containing a few degenerate nuclei. 1. individual desquamated epithelial cells; 2. cortex of the lymph follicle. 3. germ center; 4. epithelium; 5. epithelium containing few lymphocytes; 6. intense infiltration with lymphocytes; 7. desquamated "epithelia" and emigrated lymphocytes in the interior of the tonsillar sulcus (crypt).

Bauer, 1921 (page 448), called attention to the relation between anatomical and functional disturbances in the intestinal absorption areas associated with "inordinate loading" with albumen alone, which resulted in the entrance of foreign protein. How much greater, then, may such absorption become when epithelium—squamous or columnar—is decidedly atrophic or destroyed altogether! Moreover, upon the exposure of the hyperplastic lymphatic tissue to the lumen, external agents of all kinds can freely enter or attack it. Because of the great number of lymphatic nodules in the alimentary canal, an endless number of places of lowered resistance of all degrees hence can be formed through, or during, lymphatic hyperplasia alone. It is not necessary, to be sure, that more than one nodule becomes hyperplastic to intensify the allergic response or permit infection. The occurrence of local responses of lymphatic tissue are well established and that places of damage to the epithelium commonly are present in the alimentary tracts from individuals devoid of clinical signs or symptoms of disease, has been abundantly established through microscopic examination. However, it is not implied, to be sure, that loci of lower resistance are not produced in any other way or that their production must always be accompanied by lymphatic hyperplasia, infection or clinical symptoms or signs of illness.

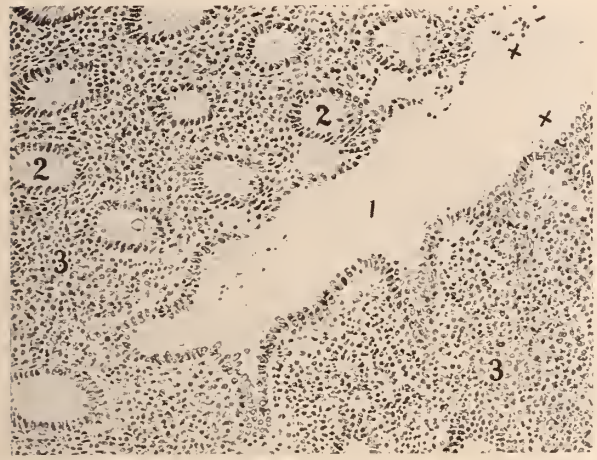

Fig. 9.—"Portion of the normal mucous membrane of appendix X150" from Kelly, 1905.—Note the absence of epithelium at X along the upper portions of the appendicular sulcus. Only the pertinent portion of the original is reproduced here. 1. sulcus in the appendicular mucosa; 2. crypts in section; 3. lymphocytes.

The atrophy and destruction of squamous and columnar epithelium of the alimentary tract emphasized here, and the related phenomena, it seems to me, offer a satisfactory answer to Aschoff's question, 1912 (page 99), as to "why the harmless residents of the appendix suddenly cause an acute attack" and confirm his conclusion, reached after a generation of study, that "The condition for the occurrence of appendicitis must reside in the normal appendix and its pathogenesis can only be studied with success on such pure cases." They further explain why "Appendicitis arises purely locally as a rule in the distal portion of the appendix" and why (page 16) "Every case of appendicitis develops on the basis of a local enterogenous infection in a specifically disposed appendix." Although not every case arises in this way, this does not invalidate my conclusion.

My observations do not confirm his belief that the cause of appendicitis "must and will be found in mechanical conditions" such as a slight flexure of the distal portion of the appendix, stressed by Aschoff. However, in so far as such very slight and severer flexures are due to asymmetrical lymphatic hyperplasia, so common not only in the appendix, or to consequent local obstruction of its lumen, mechanical conditions may, to be sure, be involved.

Furthermore, Aschoff (page 5) probably was correct in saying that "in the majority of cases, in which especially marked development of the lymph nodules, a very marked increase of the lymphatic elements . . . is present, we must think of a local or general status lymphaticus." It is of special interest that Shiota, 1909, concluded that there was a direct relationship between lymphatism and the length of the appendix and that Bauer, 1921, felt that a constitutional factor was concerned in appendicitis.

Aschoff, 1911 (page 759), claimed that in cases of acute appendicitis, six hours after the onset of symptoms of abdominal and localized pain on pressure and low fever, the "primary infect"[*] can always be found upon microscopical examination of the appendix, even when it looks entirely normal except for slight injection of the serosa. He emphasized that a sufficiently careful microscopic search always reveals a slight epithelial defect in one of the sulci in the mucosa, which contains a plug composed of leukocytes and fibrin from which a marked, wedge-shaped mass of "leukocytes" penetrates all layers of the appendicular wall, even when the serosa showed only slight evidences of beginning exudation. It is difficult to believe that the defect which Aschoff called the "Primarinfekt" actually was not a locus minoris resistentiae in the epithelium produced by lymphatic hyperplasia instead of such a manifest artifact as he represented, or that the cases of fleeting or fugitive appendicitis, of which he and others have spoken, are not occasioned by periodic hyperplasia in lymphatic nodules with the production of primary defects in the mucosa sufficient to produce disease.

DISCUSSION

The best-known characteristics of lymphatic tissue are its extraordinary variability in number, size and state, and its great lability. Passow, 1885, emphasized this in regard to the number of the intestinal nodules in different individuals, and Hofmeister, 1887, observed regressive changes in "adenoid tissue" in starvation. Stöhr, 1889, concluded that three days of starvation had greatly reduced the size of the nodules, and the withholding of food in cases of acute appendicitis, gastric and duodenal ulcers has become well established in practice. Aschoff referred to the reported infrequency of appendicitis during starvation in Russia, and the effect of diet upon lymphatic tissue was shown more recently by Settles (1920), Lefholz (1923), and Jackson (1925).

The reaction of the lymphatic nodes to physiological states such as exercise, pregnancy, etc., also is well established and they may be allergic to various inhaled as well as ingested substances. Such allergic reactions could explain recurrent light or severe attacks not only of tonsillitis and appendicitis, but of ulcer—especially of esophageal, gastric, or duodenal ulcers. The occurrence of such loci of lowered resistance, and even of open portals in the mucosa, also can account for the common presence of relatively large masses of lymphocytes in apparently normal appendices, and over tonsils, which merely are hyperplastic. Were these masses to be regarded as having been formed through individual migration through a normal mucosa that migration would have to be far more active and the lymphocytes far more resistant than known to be after their entrance into the alimentary tract.

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[*] The drawing (Fig. 19, Pl. IV, Aschoff, 1908) of a "Primarinfekt" is highly impeachable evidence, however. Such "Infekte" are present in large numbers in routine material. What is greatly needed is complete series of sections of entire appendices from persons of different ages not known to have suffered from appendicitis.

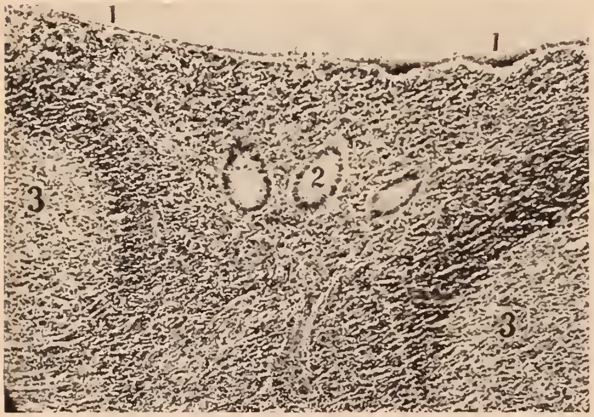

Fig. 10.—A photograph of a small portion of a transverse section of an appendix from a 32-year-old man (X75) showing the effect of lymphatic hyperplasia upon the epithelium and mucosa. 1. greatly reduced epithelium; 2. sections of a few remaining crypts; 3. lymph nodules. All the rest of the field is occupied by lymphocytes; no propria remaining. From the collection of Professor Alvin J. Cox.

The destruction of the appendicular epithelium and mucosa,* in consequence of noninfectious processes, offers a satisfactory explanation for the normal, nonpathogenic obliteration of the appendix, and can explain why that obliteration usually begins distally and why local constrictions and obliteration often occur. The lymphatic hyperplasia also offers an explanation for the so-called "erected" appendices which seem normal, and for temporary or periodic occlusions of the lumen or light passing attacks of appendicitis and for so-called "spontaneous" ulcer here and elsewhere in the alimentary tract.

That the atrophy and destruction of the tonsillar, appendicular, etc., epithelium—and mucosa—is effected from below and not from the surface, is splendidly illustrated by such specimens as represented in Figure 10. In this cross-section of an appendix from a 32-year-old male, only remnants of crypts, muscularis mucosae and epithelium remain over its entire interior. Wherever hyperplastic nodules approached near to the lumen, only an extremely thin remnant of the epithelium is left and contains some small gaps through which lymphocytes and blood have entered the lumen which contains some fecal contents. Aschoff, 1908, emphasized that he always found the appendicular mucosa intact over concretions, and the evidence that the alimentary mucosa suffers change from below in loci of lymphatic hyperplasia is conclusive. The main factors in this process seem to be interference with nutrition and lysis, not phagocytosis or disease as commonly understood. That even slight bleeding where defects exist may also facilitate infection needs no comment.

I realize, to be sure, that the constant association of phenomena does not in itself relate them as cause and effect. However, since the existence of loci of lowered resistance of all degrees from the disappearance of brush borders and goblet cells to complete destruction of the mucosa is undeniable, the manner of their production cannot affect the conclusions drawn regarding the possibility of infection through, or digestion of, damaged epithelium and destruction or sloughing of the nodules. Moreover, not only the epithelium but the entire mucosa and even portions of the submucosa may be and often are affected by the hyperplasia, including smooth muscle, etc., in the villi as well as in the muscularis mucosae. In cases of marked diffuse hyperplasia, all these structures may be involved similarly.

That the control of lymphatic hyperplasia may point the way to relief from various lesions of the alimentary tract would seem self-evident and should need no emphasis. I shall, therefore, refrain from citing manifold evidence from clinical literature in support of the conclusion presented here upon the basis of evidence revealed by others and upon personal and departmental observations and other material kindly put at my disposal by my colleague, Professor Cox.

121 Waverley Street.

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(References continued on page 240)

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* In the older literature, the word mucosa is sometimes used in a restricted sense. It, of course, includes epithelium, propria and muscularis mucosae, with the contained vessels, nerves and lymphatic tissue.

NEW TRANSVERSE LOW ABDOMINAL INCISION*

Leonid S. Cherney, M. D.
San Francisco

THE incision to be described, when compared with the vertical incisions, presents several advantages: a better exposure with lighter anesthesia, a more comfortable convalescence, a greater strength of the wound, and, incidentally, a fine scar.

It is a modification of the Maylard or Bardenheuer incision, which, in turn, is an outgrowth of the approach devised by Pfannenstiel. The disadvantage of Pfannenstiel's incision is the rather limited exposure it affords; it is, therefore, not practicable in obese patients, nor is it suitable for the removal of large tumors or for any work deep in the pelvis.

The Maylard or Bardenheuer incision differs from the Pfannenstiel incision in that all the layers of the abdominal wall—from the skin to the peritoneum—are divided in the same transverse plane. Although it provides magnificent exposure, it has failed to gain favor in this country; its lack of popularity may well be due to the unwillingness of the surgeons to section both rectus muscles, in spite of the fact that the incidence of postoperative hernia following this incision compares very favorably with the end-results of the customary vertical incisions.

The modification to be described overcomes this objection, and combines the attractive features of both the Pfannenstiel and the Maylard-Bardenheuer incisions.

DESCRIPTION

The incision through the skin is made like its prototype—a curvilinear incision, beginning from one to two fingerbreadths below and medial to the anterosuperior iliac spine, crossing the midline, running almost straight and just within the upper pubic hair line, and terminating below the iliac spine of the opposite side (Fig. 1, *A*). It is developed through the subcutaneous tissue down to the aponeurosis of the external oblique muscle and the anterior sheath of the recti. The vascularity is variable, sometimes only a few vessels require ligation; generally, however, more clamping and ligating is necessary than with a vertical incision. At either end of the incision the superficial epigastric vein is usually encountered, divided, and ligated.

The anterior sheath of the rectus muscle is nicked on either side of the midline; it is then divided transversely with scissors, and the incision is extended laterally through the aponeuroses of the external and internal oblique muscles, thus exposing the underlying recti in the center, and the fascia transversalis and the peritoneum laterally. In the more central portion the aponeuroses of the oblique muscles are fused; but, as the incision is extended laterally, two separate layers will be recognized. The fleshy fibers of the internal oblique muscle come into view about two fingerbreadths from the anterosuperior iliac spine where the incision ends. In exceptional cases the muscle may be encountered farther medially, and since the direction of its fibers is the same as that of the incision they may be split bluntly. The lower flap of the rectus sheath is grasped on either side of the midline and separated by gauze dissection from the underlying rectus muscles as far as the pubic bones. In the midline a fibrous septum (part of the linea alba) extends from the deep aspect of the sheath between the contiguous margins of the two recti (Fig. 1, *B*.) This septum must be snipped with scissors, with care to remain deep to the aponeurosis to avoid button-holing that structure; the penalty of a slit in the sheath is a possible postoperative hernia. The pyramidalis muscles are next dissected from the recti.

Near their attachment to the pubis, the recti are fibrous, frequently entirely tendinous (Fig. 2a). They are cut at their very insertion into the pubis. Even in rare cases in which the muscle fibers are abundant, bleeding is negligible. The muscles are then reflected upward.

The peritoneal cavity is first entered at either end of the incision, under the lower flap of the rectus sheath. By the insertion of the index finger into the peritoneal cavity, the height of the bladder is ascertained, and the peritoneum is incised transversely about one fingerbreadth above the line of its reflection from the abdominal wall to the bladder. In the midline the urachus is divided, and the rare instances of its patency should be kept in mind. The incision, extending from one inferior epigastric artery to the other, is usually sufficient, but there is no contraindication to dividing one or both arteries.

In the closure of the incision the peritoneum is sutured in the customary fashion. The pyramidalis muscles are allowed to fall on top of the peritoneum without any sutures, or their apex may be sutured by a single stitch to the deep aspect of the recti. The ends of the rectus tendons are securely united with mattress sutures to the under surface of the rectus sheath (Fig. 2b). Even in the cases in which muscle fibers predominate at the end of the recti, a preponderance of fibrous tissue will be found in the midline and along both lateral margins. After the insertion of the midline suture the lateral edge of each rectus muscle is sutured as far laterally as possible, encroaching on the Hesselbach's triangle.

In the earlier cases an apparently more rational procedure was employed: the rectus tendons were not detached from the pubis, but a stump was left for subsequent reattachment. However, it was discovered that the sutures had a tendency to pull out of the distal-cut end of the tendons.

Reattachment of the recti is the only part of the closure which may prove slightly difficult. However, the table may be broken so as to flex the patient's pelvis on the trunk, thus approximating the structures to be sutured. If the operation is performed under general anesthesia, the latter, hitherto very light, must be deepened at this stage; the rectus muscles have retracted, and must be relaxed to permit their reattachment without undue tension. It will be remembered that the recti are firmly attached to their anterior sheath; consequently, if the edges of the upper flap of the rectus sheath are grasped and pulled down, suturing of the lower end of the muscles will be greatly facilitated.

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* From the departments of Surgery and Anatomy, University of California Medical School.

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(Author of this paper is now overseas.)

The aponeuroses of the oblique muscles are then closed in a single layer, care being taken to pick up both layers in the lateral portions of the wound. Superficial fascia and skin are sutured in the usual way.

ADVANTAGES

This incision offers several definite advantages. The transverse diameter of the lower abdomen is about 25 per cent longer than the distance from the umbilicus to the symphysis pubis in the male and even longer in the female. Since the resultant exposure is proportional to the square of the axis, the transverse incision is capable of giving an operative field from one and one-half to two times larger than that afforded by the vertical incision. An additional advantage lies in having the center rather than the end of the incision over the operative field. Inasmuch as the overhanging fold of fat found in very obese patients is above the level of the transverse incision, it will not be in the way of the sur-

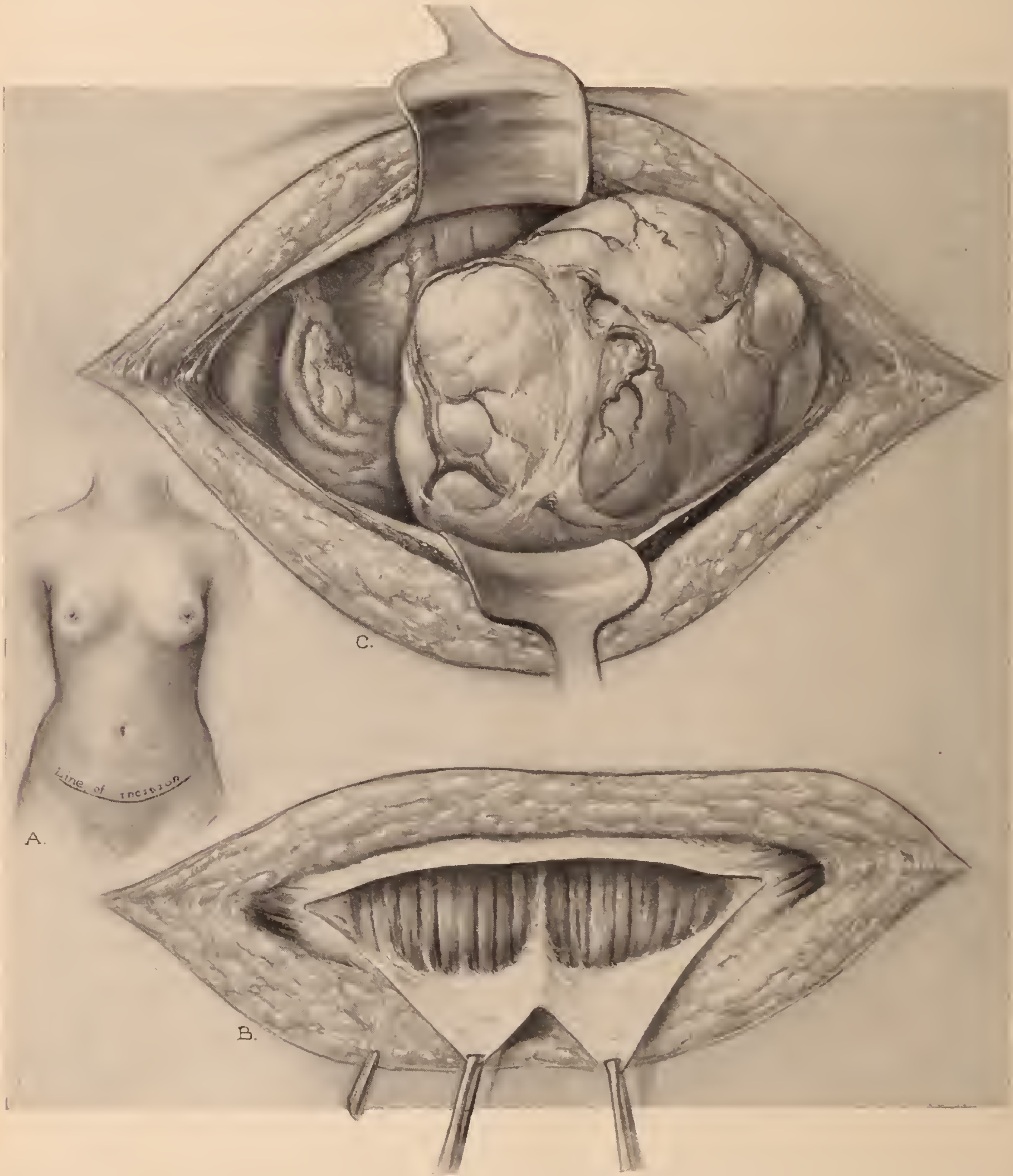

Fig. 1.—*A.* The line of incision. *B.* Elevation of the lower flap of the rectus sheath. *C.* The resultant exposure. The particular tumor was a large ovarian cyst, intraligamentous, filling the entire true pelvis and projecting into the false pelvis.

geon, thus appreciably decreasing the depth of the wound.

The exposure gives ready access to the lower sigmoid and the upper rectum, the region of the bifurcation of the aorta and the organs contained in the broad ligament (Fig. 1, *C*). Even in the male, the rectum can be mobilized as far as the end of the coccyx, under direct vision and without the handicap of working in a deep funnel. Surgeons who favor the preservation of the anal sphincter, as in the Devine procedure for excision of carcinoma at the rectosigmoid junction, will be able to remove more of the rectum, and to achieve an anastomosis deeper in the pelvis than can be accomplished with the use of the vertical incision.

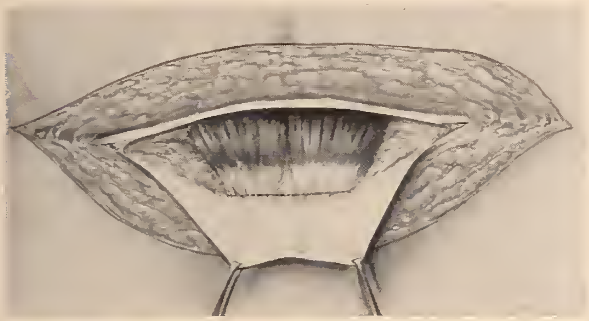

Fig. 2a.—The lower flap of the rectus sheath, elevated to expose the tendinous ends of the recti. The dotted line indicates where they are to be divided. Note the fibers of the internal oblique muscle showing at either end of the incision in the fused aponeurosis of the oblique abdominal muscles.

The incision described is not intended for general exploration of the abdominal cavity, but it will permit palpation of the liver and the performance, if desired, of the incidental appendectomy, unless the appendix is located unusually high. I have heard from other surgeons that large pelvic tumors extending to the level of the umbilicus have been delivered through this incision without difficulty.

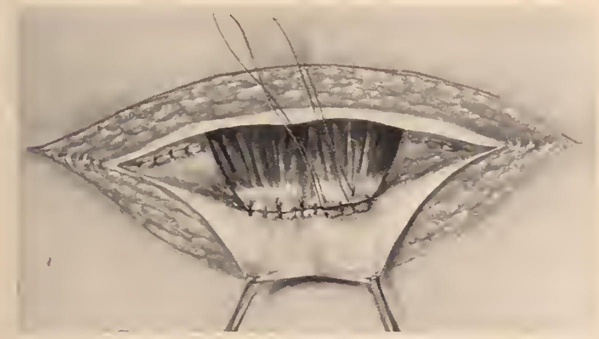

Fig. 2b.—Showing suturing of the recti to the lower flap of the rectus sheath. A second row of sutures may be inserted if desired.

The strength of the abdominal wall following this approach results from four factors: (1) no part of the muscle is denervated—the pyramidalis is of little account; (2) the aponeuroses of the oblique abdominal muscles, the recti muscles, and the peritoneum are divided at different levels—in a staggered incision, the layers of the abdominal wall are not weakened in the same place; (3) all the sutures are taken in tendinous structures which offer more secure anchorage and more reliable union; and (4) the direction of the pull of the oblique abdominal muscles is parallel to the direction of the incision in their aponeurosis. Consequently, the line of suture in this most important layer of the anterior abdominal wall is subjected neither to the constant strain of muscle pull, nor to the sudden disrupting jerk during a paroxysm of coughing. The incidence of evisceration or postoperative hernia should be negligible.

A question might arise as to why a powerful muscle like the rectus abdominis does not tear loose from its suture line once the patient begins to use it. The answer lies in the fact that the recti muscles become reattached to their sheath, not by the cut end, but by their entire anterior surface. In addition, since the recti are segmented, the greater part of the muscle pull is communicated to the anterior rectus sheath through the interscriptions; thus, the newly established union between the rectus muscles and their sheath will be subjected to the strain of the pull of only about the lower fifth of each rectus muscle.

The low abdominal incision is also attractive from the point of view of anesthesia. As the incision is below the level of the eleventh segment of the thoracic cord, spinal anesthesia need not extend higher; accordingly, there is less depression of the blood pressure. If general anesthesia is employed, it may be light, except when the rectus muscles are being reattached; no muscular relaxation is required at other times because the contraction of the muscles does not tend to close the wound. The edges of the wound gape without the aid of retractors. Very little packing is required to keep the small intestines out of the field, and for this reason there is less tendency to postoperative distention. The possibility of performing a cesarean section with minimal anesthesia makes for greater safety for the infant.

The lower abdomen is not used much in respiration even by men; consequently, the pain of a low abdominal incision is not aggravated by breathing and will have almost no inhibiting influence on respiration. Since the incision is relatively painless, the requirement of narcotics is diminished; a pillow placed under the patient's knees for the first two days will further reduce postoperative discomfort. No adhesive strapping is needed above the iliac crest, thus further promoting better pulmonary ventilation. The surprising freedom with which the patient moves in bed after operation can be easily explained by the consideration of the anatomical factors involved: the patient turns by the use of the oblique abdominal muscles; since they do not tend to pull the incision apart, their contraction does not produce pain. These same muscles are the ones primarily concerned in coughing; therefore, the patient has less dread of expectorating. The combination of relatively painless motion, respiration, and coughing leads one to expect a very low occurrence of pulmonary complications.

For those patients who judge the merits of an operation by the appearance of the scar, this incision is particularly desirable; the part which is not hidden by the pubic hair follows the natural skin lines and will eventually merge with these lines.

I have information concerning approximately one hundred of these operations that have been performed by surgeons in different parts of the country, and the results have been eminently satisfactory.

The question of how calamitous infection would be has naturally been raised. To my knowledge, there have been three infections to date; they were all limited to the subcutaneous fat, and cleared up promptly. In view of greater vascularity of this region, one may expect a lower incidence of infection here than in other locations in the abdomen.

Until we gain more information from inadvertent infections, the use of this incision is not advocated for patients in whom infection would be a likely complication. In abdominoperineal resections and other pelvic procedures with potential contamination of the wound, local use of sulfanilamide in the properitoneal, and particularly in the subcutaneous fat, is advisable.

SUMMARY

A new transverse low abdominal incision is described which has advantages in all the stages of the operative treatment. During the operation, it affords better exposure with lighter anesthesia. During the early postoperative days, it makes for greater comfort by decreasing abdominal distention and decreasing pain on deep respiration, coughing, sneezing, and moving; the incidence of pulmonary complications is, consequently, less. Ultimately, as well as immediately, the wound is strong because no muscle is denervated, the incision is staggered, all the sutures are taken in aponeurosis or tendon, and the direction of the main muscle pull is parallel to the direction of the incision; these factors should practically eliminate dehiscence of the wound in the early days, or development of a postoperative hernia subsequently. The good cosmetic result appeals to the patient as much as the other features do to the surgeon.

490 Post Street.

TROPICAL DISEASES*

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ONE of the finest chapters in the history of the United States Naval Medical Corps is being written today by the extraordinarily competent handling of the tropical disease situation by the men in the advanced units. The hospitals on the West Coast are greatly indebted to these men for their brilliant and sometimes inspired clinical reports.

MALARIA

Malaria is, of course, numerically our greatest problem, and its therapy continues to be not entirely satisfactory. A new departure in therapy first used by Lieutenant Kennedy at the Letterman Hospital is very promising. We have used several forms and combinations of therapy. The form that to date has given us the smallest number of recurrences is a combination of larger doses of atabrine, standard doses of quinine combined with the use of adrenalin and ephedrine. Our use of intramuscular doses of atabrine to secure an initial high blood level and maintenance of that level by continued oral use is insufficient, both as to number and length of time, to permit any conclusion. The intravenous route for quinine administration has achieved brilliant results for us in cerebral, and some of the other atypical malarias seen in our hospital. In our experience 90 per cent of the cases have been benign tertian, 6 per cent malignant tertian.

The clinical manifestations and immunological reactions have given some indication that the benign tertian being seen today may be a separate type from the usual strain that has been seen. Further work is now being done by Dr. Paul Michael on this problem. We have one case, a man who had been on Samoa only. This is the only case reported from this area.

INTESTINAL PARASITISM

Intestinal parasitism, though showing a high total number of cases, is not alarming when considered on a census percentage basis; as a matter of fact being almost within the same percentage limits as seen in this country. The slide shows the percentage observed to date in our hospital. Fourteen per cent of examined stools showed pathogenic forms. They have not been a serious problem.

PARAGONIMIASIS

Paragonimiasis, a rather unusual disease, was detected in our armed forces by Dr. John J. Miller, Jr. This disease has also been known as pulmonary distomiasis and endemic hemoptysis. Both of these names are open to criticism as being misleading. The infection may be found in any organ of the body, is not necessarily characterized by pulmonary involvement, and hemoptysis need not be present, though the lungs are involved. It is seen commonly in Japan, Korea, Formosa and in many isolated Far Eastern foci, including the Philippines and, with the advent of this war, Samoa.

Ova are expectorated or passed in the feces of infected man or animal, mature and hatch in water, liberating a miricidium. This penetrates the soft parts of a snail, develops into a cercaria, or the second generation form. These cercaria penetrate the chitin of the crayfish, cause a generalized infection and become encysted. These encysted forms, if eaten by man, either raw or improperly cooked, penetrate the intestinal wall, migrate through the diaphragm to the lungs, and from there to any part of the body. Some of the young worms may not penetrate the diaphragm. They have been found fully grown in the peritoneal cavity. Direct infection has been accomplished experimentally without the miricidium passing through snails and crayfish. This raises the question of the possibility of natural, direct infection occurring from the consumption of poorly prepared parts of infected animals.

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* Read before the Second General Meeting at the seventy-second annual session of the California Medical Association, Los Angeles, May 2-3, 1943.

The opinions or assertions contained therein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

Musgrave, in describing the pathology, demonstrated the flukes and ova in the lungs, pleural and peritoneal cavities, the heart, pericardium, liver, pectoral muscles, intestinal wall, the deep and superficial lymphatics, appendix, meninges and choroid plexus. He concluded that this general distribution was accomplished through the blood stream and lymph channels. He described nonsuppurative, suppurative and tubercle-like lesions.

Paragonimiasis, though generally chronic, may have a fulminating, rapidly fatal course, especially if complicated by a preëxisting disease such as tuberculosis.

The *symptomatology,* usually first presented, is referable to either the chest or abdomen, or due to lymphatic involvement. When the chest is involved, it is usually characterized by a chronic, productive cough; the sputum being thick, spotted with brownish flecks and frequently streaked with blood. One of our patients gave a *history* of repeated massive hemorrhage necessitating transfusion; this had not been previously described. Frequent, almost constant, pleural pain is the rule.

Physical findings vary, but most frequently resemble those of bronchitis. The ova found in the sputum are described as thin-walled, doubly refractile eggs measuring from 62 to 98 mu. They contain an operculum and a dark nucleus, surrounded by golden brown yolk cells. Fever varies with the course of the disease. A leucocytosis, with or without an eosinophilia, may or may not be present. In the abdominal type there is usually a dull generalized pain and tenderness with some rigidity. Not infrequently there is an increased area of liver dullness due to the presence of the fluke in the biliary passages. Bloody diarrhea is frequent. Psoas abscess resembling the tuberculous has been described. In the lymphatic type, local symptoms due to a lymphatic hypertension caused by either a partial or complete regional obstruction may occasion biopsy as means of differentiation from filariasis.

There is no specific *therapy.* Sulfonamides are used for contaminating organisms. Phenodiazine has been used, but the results are not encouraging.

FILARIASIS

The most interesting of all the tropical diseases seen by us has been filariasis, caused by the Filaria or Wuchereria bancrofti. This organism has a wide distribution in the tropical and subtropical regions of Africa, India, China, Australia, South Pacific islands, certain parts of South America, the Caribbean Islands, and in Charleston, South Carolina. The adult females average 60 mm. in length, the male 30 mm., while the microfilaria range from 150 to 300 micra in length and 7 micra in diameter.

Under well-controlled conditions forty-four different mosquitoes may serve as partial or complete hosts for the development of the mature larvae. Practically, however, the Culex Quinquefasiatus, Aedes Variegatus, and the Culex Pipiens account for the vast majority of intermediary hosts. The microfilariae, injected by the mosquito, undergoes three metamorphic changes, migrates to the labellum, and as the adult larvae can then cause the infection. After the bite, the larvae, being lymphotactic, enter the skin and lymphatics, and are carried to the deeper lymphatics, where they develop into the mature worm, mate, and parturate.

The *clinical picture* seen in these cases is that of a subacute lymphangitis, recurrent, linear, elevated, hyperemic, and at times very painful. It proceeds peripherally, leaving during the stages of remissions some distinct induration of the lymphatic channels, with enlargement of the lymph nodes. It may involve one or both upper extremities, one or both lower extremities, and in a certain percentage, the spermatic cords and testicles. Combinations of these may occur in the same patient.

Classically, this infection is supposed to be divided into four phases, namely: the incubation period; the second, or symptom-free period; next the lymphangitic phase; and, finally, the chronic stage of Elephantiasis. We have observed the first three phases, but not the classical elephantoid phase. To date, no microfilariae have been seen in the peripheral blood.

Thirty per cent have been proved out by biopsy studies with the demonstration of the adult or adolescent worm, both male and female. The remainder of biopsies, although not actually showing the worm, were presumptive, in that the classical granulomatous lesion of this disease was observed, with typical granulation tissue and eosinophilic infiltration. The symptoms seen in the lymphangitis stage are probably due both to mechanical blocking by filariae, together with an allergic reaction between the human host and the products of the worm. Culturally, our cases were sterile except in one instance, where the lesion was superficial and communicated with the outside skin.

It is felt that these patients will be cured spontaneously simply by foreign-body engulfing of the worms as a natural course of body resistance. Relapses, of course, will follow before this cure will be effected. There is as yet no specific therapeutic agent known, although most drugs have been tried. It had been our reaction that surgical removal of superficial foci has resulted in improvement of the patient. Surgical intervention of the spermatic cord lesions, however, is strongly advised against, as lesions of this nature usually undergo exacerbations after this procedure.

Discussion.—The laboratory diagnosis of endemic filariasis in the natives, as seen in Samoa and other islands of the South Pacific, usually offers little problem. The finding of the microfilaria of filariae bancrofti in the blood is a most usual event in large numbers of the natives of these islands. The incubational period of approximately eight months to one year from the time of infection to the appearance of the microfilaria in the blood, however, renders the proof of infection in the military personnel a somewhat more difficult problem. The differential diagnosis, from the clinical point of view, is obviously fraught with many complexities. Atypical Malaria brucellosis may simulate Filariasis. Moreover, the finding by the laboratory aides of Paragonimus ringeri in several patients returned from Samoa, discloses another disease which may simulate Filariasis in its early forms. As a matter of fact, these diseases may even exist simultaneously in the same patient. Therefore, every possible laboratory aid to the diagnosis of filariasis must be brought into use. Space does not permit the various tests which may be used in the diagnosis or ruling out of such allied conditions as are named above, except that it should be born in mind that Paragonimus ringeri, or P. westermanii, may lodge in the lymphatics of the extremities or spermatic cord, and in doing diopsies, care should be used in not overlooking any possible presence of ova. Stool and sputum examinations in this condition are also of great aid.

In approaching the *diagnosis* of Filariasis in men who have been in endemic localities, the time interval is of first importance. It is unlikely that microfilaria will be seen in the blood or hydrocele fluid of men with incubation periods of less than eight months to a year. Search should be made, however, even in doubtful cases. Ordinary blood smears, preferably around eleven o'clock at night, should be made, using thick smears. The concentration technique of Knott, however, may be used both in day and night examinations. This technique employs the use of 1 c.c. of blood in 10 c.c. of 2 per cent formalin. This is allowed to sediment for from twelve to twenty-four hours, and the sediment used for thick smear preparations. Giemsa, Wright's or Loeffler's methylene blue-eosin stains may be used. Unfortunately, this rather simple diagnostic method is of little help in the patients who may be in the incubational asymptomatic, or early acute stages before the worms have become sufficiently mature to produce microfilaria.

In the lymphangitic stage the most valuable aid is the removal of tissue for biopsy examination. Certain important points in this procedure should be followed, namely, choice of site for biopsy, and the use of serial sections, if single sections fail to reveal the adult or adolescent worms. As the worms apparently seem to follow a retrograde movement distally in the lymphatic chains, the choice site of the biopsy should, if possible, be the most distal lymphatic involvement. Biopsy of the cord-like structure is more desirable than the lymph node itself, as lymph nodes may show only a drainage type hyperplasia with eosinophile infiltration and edema. There is a rather characteristic granulation tissue produced by the lodgment of the worms in the lymphatic or other soft tissues. A tuberculoid reaction is observed around the engulfed worms, many of which may be in the process of death or absorption. In identifying the mature or adolescent worms, care should be observed in recognizing certain aspects of the morphological characteristics. The cuticle of Wucheria bancrofti is smooth, the spicules are unequal, and in the female the uterus is double on cut section. The vulva of the female is preëquatorial, usually in the esophageal region. The posterior end of the male is sharp, with a ventrad curve, while in the female it is blunt. If a suitable biopsy is taken from the soft tissue lesions, little difficulty should be encountered in establishing the diagnosis.

Other tests, now not commonly used, but of distinct help, are the alexin-fixation and the intracutaneous reactions. Alcoholic and aqueous antigens derived from fresh or dried Dirofilaria immitis and Onchocerca vuloulus.

There is no specific treatment. Local measures, as wet packs, elevation, etc., are used for the relief of the acute lymphangitis. Surgery is resorted to in the elephantitic stage.

A typical report from the department of pathology is as follows:

Microscopic.—The microscopic sections show lymphatic tissue undergoing endothelial and fibrous hyperplasia. Several dilated lymphatic channels can be seen containing adult filarial segments, many of which are undergoing early calcification. The endothelial cells proliferate radially from the channels, and the nuclei of the cells nearest the hub show pyknosis. This reaction causes a picture simulating palisading with formation of pseudo-rosettes. In same places the fibrous tissue is young and immature, composed of proliferated fibroblasts, while in the others it is old, homogeneous, hyalinized. Round cells are numerous and extend out into the fat and muscle. Endothelial cells occasionally are fused and show pseudo-giant cell formation. Eosinophiles are numerous and in many places the eosinophilic granules have broken out of the cell membranes, but may be seen scattered as fine, red, dust-like particles between the cells. There appears to be some attempt to collateral lymph circulation.

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VIRUS PNEUMONIA: A REVIEW OF THE PATHOLOGY*

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SECONDARY bronchopneumonia is of fairly frequent occurrence, but primary bronchopneumonia, except in pandemics of influenza or streptococcal epidemics, is rather rare. However, in recent years there has been a growing number of reports of pulmonary disease of undetermined origin. In 1935, Bowen[1] called attention to a form of pneumonitis observed in troops in Hawaii which produced but few clinical signs except for râles, and was mild, but x-ray showed spotty shadows extending into the lower lobes. Cough and low leukocyte counts were characteristic. Cultures from the sputum gave no indication as to the etiology. Allen,[2] in 1936, described a similar mild form of pneumonia at Fort Sam Houston, where the physical signs were scant but x-ray revealed areas of pulmonary consolidation. All recovered and the etiology was unknown. Smiley, Showacre, Lee, and Ferris,[3] in 1939, described a similar form of pneumonia spreading through the student body at Cornell University, with eighty-six cases during a period when influenza was not pandemic. All recovered. They described it as an interstitial pneumonia not due to pneumococci. In 1938, Reimann[4] of Philadelphia reported eight cases of acute infection of the respiratory tract with atypical pneumonia and suggested a virus as the cause, but he did not believe that the disease was influenza. Stokes, Kenney, Shaw,[5] and Francis, studying nose and throat washings and blood from two of Reimann's cases, obtained a filterable agent capable of producing pneumonia and encephalitis in mice, guinea pigs, and possibly ferrets, but the strain was eventually lost in animal passage. The guinea-pig lungs contained bluish-gray areas of firm, patchy bronchopneumonia. Microscopically, the inflammatory changes were of both lobar and peribronchial distribution. The bronchiolar epithelium was piled up into swollen folds with vacuoles and the lumen contained mucopus. The wall of the bronchi was thickened and highly vascular. The alveolar exudate was made up chiefly of mononuclear cells and fibrin, with occasional clumps of polymorphonuclears, but no destruction of lung tissue or abscess formation. Serologic study of Reimann's patients indicated that the illness was not due to epidemic influenza virus. Animal studies indicated that it was not the psittacosis virus or that of meningopneumonitis, but rather some new filterable agent which was the cause of the disease in Reimann's patients. Maxfield,[6] in 1939, analyzed sixty-three cases of an atypical leukopenic pneumonia occurring in epidemic form with unknown etiology and complete recovery. Murray,[7] in 1940, published an excellent account of 146 cases of atypical bronchopneumonia observed among the students at Harvard. The average case presented a normal or slightly elevated leukocyte count. The initial counts were 5,000 to 12,000 with 70 to 75 per cent polymorphonuclears. In about one-third of the cases there was a curious rise in the count during convalescence, occasionally reaching 17,000 to 20,000. While this might be taken to indicate the onset of some complication such as empyema or lung abscess, none appeared in this group. The convalescence was rapid and no deaths occurred. The majority of sputa contained no pneumococci but a variety of organisms. Blood cultures were negative. The urines were negative except for occasional transient albuminuria and, very occasionally, small numbers of red cells in the centrifuged sediment. Attempts to isolate a filterable virus were unsuccessful.

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* From the Department of Pathology, Stanford University School of Medicine, San Francisco.

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Weir and Horsfall,[8] of the Rockefeller Foundation, isolated a virus capable of producing pulmonary consolidation in the wild mongoose from throat washings of patients with acute pneumonitis. This virus differed from other viruses known to cause infections of the respiratory tract in man. The lung lesions in the mongoose were circumscribed areas of plum-colored consolidation with gelatinous consistency and generalized pulmonary hyperemia. Microscopically there was extensive edema, distending the alveolar spaces and thickening the septa. The sparse cellular exudate was almost entirely of mononuclear cells. The bronchial epithelium was well preserved and the lumina contained protein-rich edema fluid.

Kneeland and Smetana,[9] in 1940, reported fifty-two cases of primary bronchopneumonia in New York with one death. The leukocyte counts early in the disease were only slightly elevated, if at all, with a rise in the number later in the disease. The sputum was scant and rarely rusty and, from a bacteriological standpoint, was entirely comparable to that of healthy individuals. They were impressed by the lack of secondary bacterial infection of the lungs. Whereas the influenza pandemic of 1918 gave abundant proof that influenza encouraged all sorts of bacteria to invade lung tissue with disastrous results, the reverse seemed to be true in their 1940 series. The urine contained none or a slight amount of albumin with normal renal function. There was some evidence of liver changes in a few of the severe cases, as indicated by slight jaundice, reversal of the serum albumin-globulin ratio and bromsulphthalein retention. The single death was a female of 47, who was ill ten weeks with pneumonia of both lungs. No pneumococci were recovered from the sputum. She did not respond to sulfapyridine. There was no leukocytosis. The complicating features were thrombophlebitis of the legs, anemia, hypoproteinemia, and heart failure. The lungs contained many small, pink to gray, airless patches projecting slightly above the surface with moderate intervening emphysema. The bronchi were congested and contained thick mucopurulent exudate which yielded Type 10 pneumococci. Microscopically there was a varied lung picture indicating different stages of the disease. The earliest lesions were a hemorrhagic exudate of red cells, blood plasma, and a few mononuclear wandering cells within the alveoli and a mild infiltration of the septa by similar cells. Later stages showed an organization of the alveolar exudate, with the spaces growing smaller and the septa thicker. Many alveoli were solidly filled with mononuclears containing fat droplets and hemosiderin granules. The septal thickening was due to fibrosis and mononuclears. The mucosa of the larger bronchi and trachea was densely infiltrated by polymorphonuclears and mononuclears, and the lumen contained mucopurulent exudate. No inclusion bodies were seen in any of the sections. Moderate-sized branches of the pulmonary arteries showed an extensive, eccentric necrosis of the walls which were infiltrated by polymorphonuclears, mononuclears, and eosinophils, extending into the adventitia. The spleen gave the picture of an acute splenic tumor. The liver had areas of focal necrosis and large mononuclears scattered through the lobules. The kidney findings were interpreted as a nephrosis, probably due to medication with sodium sulfanilate. Although the etiology of the disease which they reported was unclear, they found the virus hypothesis the most attractive.

Longcope,[10] in 1940, reported thirty-two cases of a form of leukopenic bronchopneumonia which he called "Variety X." Blood cultures, agglutination tests, and sputum examinations yielded no indication of the etiologic agent. Two of this series did not recover:

One was a man of 38, who died in seven days with marked cyanosis. Autopsy revealed a mitral stenosis and insufficiency of rheumatic origin. The lungs were heavy and boggy with no pleurisy. Large areas in both lungs felt almost consolidated, but cut sections showed them rather filled with fluid than consolidated, and there were small, 2-4 centimeters, patches of dark, red, raised areas of consolidation. Microscopically the bronchi contained thick exudate of polymorphonuclears and round cells. Their walls were infiltrated with similar cells. The surrounding alveoli were solidly filled with mononuclear cells with no polymorphonuclears. Bacterial stains revealed no organisms. Elsewhere the alveoli were air-bearing or filled with edema fluid. Inoculation of lung tissue into mice and ferrets produced no positive results.

The second fatal case was a man of 40, who had been under observation for several years for myocardial failure from rheumatic heart disease involving the aortic valve. The initial leukocyte count was 4,600 with 90 per cent polymorphonuclears with a gradual rise to 10,400. The sputum contained no organisms pathogenic for mice. He died in eleven days. Autopsy: The lungs were dark red and hemorrhagic, with a fine fibrinous pleurisy over an area of consolidation in the left lower lobe. The bronchi were filled with tenacious mucus. Microscopically there was hemorrhage, edema fluid, macrophages and polymorphonuclears in the peribronchial alveoli, sometimes showing organization. Some of the radicles of the pulmonary artery showed necrosis and cellular infiltration of the wall. Cyanosis was a prominent feature of these two patients, both of whom had chronic rheumatic heart disease. The etiology of Longcope's "Variety X" bronchopneumonia is unknown, but he believed that it was some form of virus.

Adams,[11] in 1941, reported thirty-two cases of primary virus pneumonitis of infants in Minneapolis during a three-month period, with nine deaths. At autopsy the lungs were congested with scattered nodular areas of hemorrhagic pneumonia. Microscopically there was necrosis and ulceration of the bronchial epithelium with sloughing into the lumen, and patches of peribronchial infiltration of mononuclears. Polymorphonuclears, lymphocytes, and large mononuclears filled the alveolar spaces. All nine cases showed characteristic cytoplasmic inclusion bodies in the bronchial epithelial cells. The cytoplasm was often vacuolate with the inclusion body near the nucleus staining red with hemotoxylin and eosin. Fresh lungs were sent to Francis, who was unsuccessful in isolating a virus. Serum from ferrets inoculated with this material failed to show antibodies capable of neutralizing influenza virus and inclusion bodies have not been found in influenza. Adams concluded that the epidemic of pulmonary disease which he described was due to a virus as indicated by its high degree of contagiousness, by its distinctive symptomatology and pathology and by the failure to identify a causative bacterium.

Dyer, Topping, and Bengtson[12] report an epidemic of pneumonitis comprising fifteen cases among 153 employees in one building of the National Institute of Health in the spring of 1940. The causative agent was identified as the rickettsia of "Q" fever. All but one patient recovered. The disease was characterized by normal leukocyte counts with more than 70 per cent polymorphonuclears, negative blood cultures and agglutination tests, no consistent sputum flora, minimal chest findings by physical examination, but definite signs of bronchopneumonia by x-ray. Strains of "Q" fever virus had been carried in animals and tissue cultures in this building since 1938. Whether or not this served as a source of infection is open to question, since the personnel of this unit were spared and the cases were widely distributed throughout the building. Lillie, Perrin, and Armstrong[13] reported the pathologic findings of the one death from "Q" fever. The lungs were congested and edematous basally with firm gray granular consolidation of the right upper lobe. The spleen was enlarged, soft, and flabby. Microscopically there was a diffuse alveolar consolidation, with fibrin as the chief component enmeshed, in which were varying numbers of lymphocytes, plasma cells, and large mononuclears. Red cells were numerous in scattered alveoli, but polymorphonuclears were rare. Proliferating fibroblasts and alveolar epithelium were prominent. The alveolar septa were moderately thickened with fibrous tissue, lymphocytes and large mononuclears, and the capillaries were empty. The bronchioles were usually completely occluded by exudate. This pneumonic process appears to have been essentially the same as that described by Kneeland and Smetana,[9] and Longcope.[10] The spleen showed congested pulp, few polymorphonuclears, and moderate numbers of large lymphoid and plasma cells. No rickettsia were seen. Eight rhesus monkeys inoculated with the four strains of "Q" fever virus isolated from this epidemic presented essentially an identical picture to the human case.

REPORT ON SAN FRANCISCO CASES

Through the kindness of Dr. A. M. Moody, I shall briefly describe six cases of influenza-like bronchopneumonia occurring early in 1940 in San Francisco which were closely connected epidemiologically. Three of the six patients died after a brief illness. The physical chest findings were scant, but x-ray studies showed bronchopneumonia. Autopsies of two of these revealed a pseudolobar pneumonia with edema, hemorrhage and irregular areas of tannish-gray, moist consolidations with emphysematous margins. The spleens were enlarged and soft. Microscopically, the pulmonary alveoli were filled with serum and a coarse network of fibrin containing large mononuclear cells, red cells, and only rare polymorphonuclears. The alveolar septa were thickened due to congestion, mononuclear infiltration and swollen epithelium. (Fig. 1.) Some of the bronchi contained desquamated epithelium, fibrin, mononuclears, and many polymorphonuclears; however, there was only a slight inflammatory reaction present in their walls. Specimens of the lungs, liver, and spleen were sent to the Virus Research Laboratory of the California State Department of Public Health and the findings were reported by Eaton, Beck, and Pearson [14] as a virus antigenically related to psittacosis. They described the lungs of the inoculated mice as showing many small bluish-gray focal lesions. Microscopically, there were dense accumulations of mononuclear cells with a few small patches of polymorphonuclears in the alveoli. The septa were swollen. Other alveoli contained fluid. In August, 1940. Moody examined a similar patient expiring in another San Francisco hospital where autopsy material submitted to the Hooper Foundation was found to contain the psittacosis virus. Foord,[15] in 1934, reported a proved case of psittacosis in Pasadena with pathologic findings practically identical with those described above.

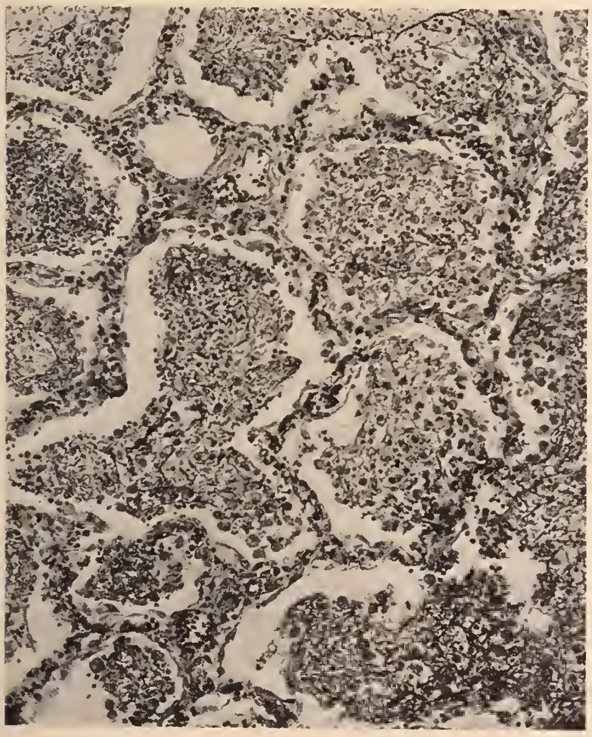

Fig. 1.—Microscopic section of lung showing mononuclear cells, erythrocytes and fibrin in alveoli (x 200).

In 1935 [16] and 1937,[17] Cheney described a puzzling febrile illness observed in twenty cases in the San Francisco Bay district, the etiology of which was unknown. The findings were so like those seen in cases of dengue fever that this diagnosis was seriously considered. He compromised by calling it a dengue-like fever. He expressed the opinion that it seemed most likely that the etiology of the disease was a filterable virus. Although no virus was isolated, he was able to reproduce the disease by intravenous injections of blood from patients into four volunteer persons. In reviewing the clinical picture of these cases reported by Cheney, it seems most probable that it was the same illness that we now know as virus pneumonia.

During the past year Cheney and Gardner [18] have compiled records of twenty-eight cases of so-called virus pneumonia in Stanford Hospital in San Francisco characterized by fever, initial leukopenia or normal leukocyte counts with polymorphonuclears somewhat higher than normal, and minimal chest findings by physical examination but definite areas of shifting pulmonary consolidation by x-ray. Sputum examinations revealed only the usual flora. Prostration was often severe, but there were no deaths. Sera of eight of these patients were studied by the Weil-Felix agglutination test and seven proved positive. The one negative test was made ten months after recovery. This test is widely used in the laboratory diagnosis of rickettsial diseases. The finding of seven positives out of the eight sera tested is certainly highly suggestive that these patients may have been ill with a rickettsial disease, and further investigations are now in progress. Agglutination tests for "Q" fever were run on several of these patients and found negative. Complement-fixation studies for virus made by Eaton on bloods from eight other patients in this series were negative.

DISCUSSION

In reviewing these recently reported outbreaks of primary bronchopneumonia, there is noted a marked similarity of clinical history and laboratory findings. In the main, no specific etiologic agent has been isolated, but the diseases possess many features which indicate that they are probably caused by some virus or viruses. The pathologic changes in the lungs of the few cases coming to autopsy are quite similar to those of known virus etiology and are characterized by alveolar exudate consisting largely of mononuclear cells, with polymorphonuclears conspicuously rare. In a small group of cases in San Francisco, a virus antigenically related to psittacosis was found responsible for the pneumonia, and the mortality rate was very high (50 per cent). The Washington epidemic [12] was caused by "Q" fever virus, resulting in only one death. The viruses isolated at the Rockefeller Institute [8] and in Philadelphia [5] have not as yet been identified. The same is true for the inclusion bodies consistently found in the Minneapolis epidemic[11] in infants, which carried a mortality rate of 20 per cent. It seems obvious that several viruses are responsible for producing quite similar disease pictures. Many of the reports refer to the occurrence of the disease among college students, hospital personnel or in garrisoned troops, and there is abundant evidence that the infection is readily transmitted.

2398 Sacramento Street.

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(References continued on page 240)

CLINICAL NOTES AND CASE REPORTS

FECAL IMPACTION

REPORT OF UNUSUAL CASE

Angelo M. May, M. D.
and
Emile Torre, M. D.
San Francisco

It is desired to report an unusual case of fecal retention.

REPORT OF CASE

Case 1.—Mrs. F. G. came to our attention on February 24, 1942. She gave no unusual history other than the progressive enlargement of her abdomen over a period of two years. On the patient's word, no bowel movement had been expelled for a period of a year and a half.

The patient was a member of a family which included mental defectives, and her own word could not be relied upon; however, competent members of her family expressed the certainty that, for at least the last six months, the patient's story was correct.

Physical examination revealed an emaciated woman of 52, with an abdomen enlarged to the size of at least a full term pregnancy. Rectal examination revealed a large ovoid mass, reaching from beyond the rectum to the costal angle.

As the uterus was movable, it was felt that the probable diagnosis was that of a large ovarian cyst. The patient's story of obstipation was believed untenable.

Operation was performed on February 26, 1942, at which time the lower abdomen was opened through a midline incision. There came immediately into view a large, firm mass which had the appearance of a mammoth ovarian cyst, which extended far into the pelvis and above the xiphoid. There was no possibility of delivering the mass through the wound, so a trocar was inserted to ascertain the properties of the contents. No fluid escaped, and when the trocar was removed, substance resembling inspissated fecal material was found in the shaft of the instrument.

The opening in the mass was further enlarged and the true nature of the tumor became apparent. The descending colon from the splenic flexure to the sigmoid had become enormously dilated with feces, the bowel wall thinned to a cyst-like appearance. The patient had not exaggerated her complaint, for a bucket-full, or approximately five gallons of inspissated fecal material were removed. Search was made for an obstructive growth but none could be found. After removal of its contents, the bowel contracted down to a semblance of its former self, although it remained approximately three times the diameter and thickness of adjacent colon. The opening in the bowel was closed with inverting gastro-intestinal chromic suture. A loop colostomy was brought out above the metamorphic bowel, as it was apparent the dilated bowel was not ready to resume peristalsis. Eight grams of sulphanilamide were placed in the abdomen to prevent infection. The patient's recovery was uneventful. The colostomy was opened on the second day.

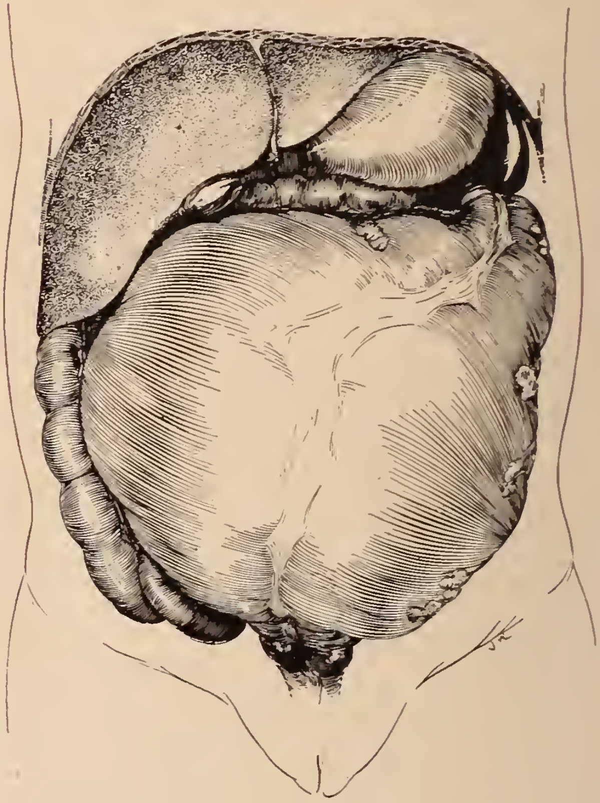

Fig. 1.—Showing enormously dilated descending colon filled with fecal material.

On the tenth to the twelfth day, the septum was crushed and fecal matter was thereafter passed into the lower segment of bowel and expelled per anus.

On the thirty-second day, the patient developed an intussusception of her large bowel, the double loop extending for a distance of 12 inches. This was reduced, however, with ease, and two days subsequently the colostomy closed and buried beneath the external oblique fascia.

Since this time the patient has had normal bowel movements, and has improved in physical appearance and strength to normal of her age.

COMMENT

This case, it is felt, demonstrates the extreme of fecal retention and the possibility of survival without defection over a long period of time. Because of the recovery made and the ultimate restoration of normal bowel activity, the authors feel that this case was a true fecal impaction, rather than a megacolon of the Hirschsprung type.

450 Sutter Street.

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CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Mobilization of the Emergency Medical Service on Air Raid Alerts

OFFICE OF CIVILIAN DEFENSE
Washington 25, D. C.

Circular.—Medical Series No. 33. Issued on September 13, 1943.

To: Regional Directors and Regional Medical Officers.

FROM: Dr. George Baehr, Chief Medical Officer.

Attention is directed to Operations Letter No. 139, subject: Mobilization and Demobilization of Civilian Protection Forces. This Circular reviews the timing of mobilization of Units of the Emergency Medical Service in accordance with the Operations Letter.

YELLOW WARNING

1. *Chief of Emergency Medical Service and Deputies*

The Chief of Emergency Medical Service and his Deputies assigned to duty at Control Centers should receive the yellow warning and proceed immediately to their designated posts.

2. *Hospitals*

All Casualty Receiving Hospitals should receive the yellow warning, which should be relayed immediately to the administrator, and superintendent of nurses, and the chief engineer.

BLUE WARNING SIGNAL

1. *Mobile Medical Teams*

(*a*) Teams composed of resident personnel of hospitals prepare for action by assembling, with equipment, at a designated point in the hospital, and stand ready for orders from the Control Center.

(*b*) Teams composed of persons from the neighborhood of a hospital assemble at the hospital.

(*c*) Teams designated to assemble at Casualty Stations remote from a hospital report to the Casualty Station.

2. *Stretcher Teams*

Stretcher Teams on call assemble at their posts of duty at hospitals or Casualty Stations.

3. *Ambulance Teams.* (Driver and Attendant)

(*a*) Teams composed of persons on duty at a hospital or depot at which the ambulance is parked prepare their vehicles and equipment for action.

(*b*) Teams composed of persons residing in the neighborhood of hospitals or ambulance depots assemble at the hospital or depot at which they are on call.

4. *Hospital Personnel*

The following will report to the hospitals to which assigned: physicians on shock, surgical, triage, fracture, or other emergency teams; anesthetists; nurses and Volunteer Nurses' Aides on call at the time for emergency duty; hospital protection personnel such as Wardens, Fire Guards, Messengers, and essential maintenance personnel.

In preparing hospitals for action, every effort should be made to reduce to a minimum the movement through streets. Hospital administrators and Chiefs of Staff should, therefore, determine their minimal requirements and recommend emergency personnel for membership in the U. S. Citizens Defense Corps or the Civilian Defense Auxiliary Group (see Operations Letter No. 37 and Supplement No. 1 thereto). The Chief of Emergency Medical Service should arrange for the appointment, training, and proper identification of such emergency personnel.

RED WARNING SIGNAL

Members of the Emergency Medical Service stand by at their posts throughout the red warning period until dispatched to incidents or Casualty Stations on orders from the Control Center. The physician in charge of a Mobile Medical Team at a hospital or Casualty Station may send forward a Stretcher Team or other personnel to near-by incidents on his own initiative.

OMISSION OF YELLOW OR FIRST BLUE WARNING

The sudden or rapid approach of enemy planes may prevent the giving of either the yellow or blue warning, or both. In the event that a red warning is given without preliminary warnings, Emergency Medical Service personnel will immediately take the action normally taken on the yellow and blue warnings.

BLUE WARNING SIGNAL FOLLOWING RED

Emergency Medical Service personnel remain at assigned posts or at posts to which they have been dispatched until relieved by the Chief of Emergency Medical Service.

ALL CLEAR

Emergency Medical Service personnel remain at their posts of duty until relieved by the Chief of Emergency Medical Service.

NOTE.—When practice drills are planned in advance, the Chief of Emergency Medical Service may excuse all or part of the physicians who have taken part in previous drills from participating in the exercise. Unless specifically excused in advance, physicians and other personnel of the Emergency Medical Service should mobilize on every alert in accordance with the above outline.

Medical Journals—For Colleagues in Military Service

In former issues, editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy, and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The addresses of the three libraries follow:

University of California Medical Library, The Medical Center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals via "Railway Express Agency," collect, to: California Medical Association Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261). The "Railway Express Agency" will call for packages and will collect costs from the California Medical Association. The Postgraduate Committee will forward to camps.

Eye Deficiencies Chief Cause for Draft Ban

Eye defects were the chief cause for rejection of 18 and 19-year-old selective service registrants by the Army in the three months' period from last December to February.

In this age class, 23.8 per cent of all white youths summoned for induction were rejected, and 45.5 per cent of all negroes called were turned down.

Only part of the rejections were for physical reasons. Other reasons included previous enlistment, enrollment in a specialized course of training and employment in vital industry and agriculture.

Among white youths the principal causes for rejection, after eye defects, were listed as mental disease, muscle and bone defects, heart and blood vessel defects, ear defects, hernia, neurological defects, educational deficiency, underweight, and mental deficiency.

Among negroes the nine leading causes of rejection in the same age group were social disease, heart and blood defects, mental disease, muscle and bone defects, hernia, eye defects, neurologic defects, mental deficiency, and tuberculosis. Half of the rejections of negro youths resulted from educational deficiency and social disease.

Association of Military Surgeons of the United States

Rear Admiral Ross T. McIntire, Surgeon-General of the United States Navy, and personal physician to President Roosevelt, will serve as honorary chairman for the fifty-first annual convention of the Association of Military Surgeons of the United States to be held in Philadelphia on October 21, 22, and 23.

A symposium on war medicine, which will chart the progress and the recent advances made in the care and hospitalization of men in the armed forces will highlight the three-day meeting in the Bellevue Stratford Hotel.

Officials of the convention expect an attendance of more than two thousand doctors now attached to the fighting forces, many of whom will return from the battle fronts and from every section of the country where men are stationed, to hear the lectures and to take part in the panels and discussions that will mark the conference.

The surgeons-general of the United States, ranking military officers, and national, state, and municipal officials are expected to be present at the convention.

Maternity-Pediatric Plan of Federal Children's Bureau

(Additional items—Continued from pages 79-88, CALIFORNIA AND WESTERN MEDICINE, for July (Items I to XVIII), and September, pages 178-182 (Items XIX to XXIII).)

ITEM XXIV: MATERNITY-PEDIATRIC

United States Child Care Fund Increased

Washington, Sept. 22.—The House Appropriations Committee, estimating there will be 645,000 pregnancies among wives of enlisted service men during fiscal 1944, today recommended $18,620,000 deficiency appropriation for the Government's maternity and child-care program.

When the program was first started, the Committee said, it was estimated that the total number of pregnancies would be 300,000 and that 25 per cent of the wives would apply for Government care.

Later experience showed, however, that the number will be more than doubled and that 50 per cent of the wives are seeking aid, the Committee added.

Before the summer recess, Congress appropriated $6,600,000 for the maternity and child-care program in the belief then that this amount would carry it for the entire twelve months.—San Francisco *News*, September 22.

* * *

House Passes Baby Fund

Washington, Sept. 22 (AP).—Without a dissenting vote, the House passed and sent to the Senate today a bill appropriating $18,620,000 for assistance to service men's wives who become mothers.

The appropriation supplements $5,600,000 provided for the same purpose since last March, but already spent at an average cost of $84.50 per case.

The House voted down, 115 to 8, a proposal that the aid be given in cash to the mothers, and ordered instead that it be used to pay medical, nursing, and hospital bills direct.

ITEM XXV: MATERNITY–PEDIATRIC

A Bad Precedent in Dangerous Times

The future of safe maternity care for the mothers and babies of America hangs in the balance this summer. It hangs there because an attack has been made on the high standards which have been developed by the medical profession, the health departments, the Maternity Center Association, the Federal Children's Bureau, and civic-minded citizens during the past quarter of a century. We have been very proud in recent years of the rapidly declining maternal mortality. In city after city and state after state, almost miraculous declines have occurred in the number of deaths and injuries to mothers and babies before, during and after birth.

What has caused these declines? All who are familiar with the situation know that the increasingly high standards of obstetric care are largely responsible. Doctors and nurses have taken refresher courses. The standards of teaching in medical and nursing schools have been improved. New advances have been made in chemotherapy; in the control of infection, toxemias, hemorrhage; in pelvimetry to avoid needless difficult and dangerous labor; in surgery to make cesarean sections safer and in the safe relief of all unnecessary pain. The great scientific advances in the care of premature babies have been made available in thousands of communities.

Wherever these new high standards have been put into practice, maternal and infant deaths have drastically fallen. In the States and among the groups of our population where they have not been put into practice, needless death and injury still take a ghastly toll of life and health among mothers and babies.

This is an important time in our nation's history, for all forward-thinking professional people and civic-minded citizens are convinced that the benefits of these new scientific advances made by the medical profession must be made available to every mother and her baby, regardless of her ability to pay. Never in our nation's history have high standards mattered more, for precedents are being set that may have their effect in the legal framework of our nation for years to come.

At this critical moment, when high standards are being unanimously accepted and states, where standards have been low are striving to raise them quickly, Congress, over vigorous protest, passed an innocuous-appearing amendment to the appropriation for the Children's Bureau, relating to the provision of care for the wives and babies of service men. In legal language this amendment says: *"That no part of any appropriation contained in this title shall be used to promulgate or carry out any instruction, order or regulation relating to the care of obstetrical cases which discriminates between persons licensed under state law to practice obstetrics: Provided further, That the foregoing proviso shall not be so construed as to prevent any patient from having the services of any practitioner of her own choice, paid for out of this fund, so long as state laws are complied with."*

The Standards Are Revoked

The immediate result of this amendment was to require the Chief of the Children's Bureau to send the following memorandum to the various state health departments throughout the country: *"All instructions previously issued by the Children's Bureau requiring such minimum qualifications for physicians participating in the maternal and child health and emergency maternity and infant care program in so far as such instructions relate to the care of obstetrical cases are hereby revoked. In approving state plans in the future, the Children's Bureau will not pass upon the standards set forth in such plans for practitioners performing obstetrical services thereunder. The Children's Bureau, in its consideration of such standards, will pass solely upon the question whether state laws have been complied with."*

This means that the Children's Bureau is deprived of the right to suggest standards of obstetric practice for the expenditure of this money. But more than that, in human terms, it may mean the life and the health of many a mother and her baby. Under the terms of this amendment, the wife of a service man, who is expecting a baby, may, in her ignorance, select a cultist who is licensed to practice obstetrics in his State and who, under the law, may be paid from federal funds. He may be unable to use medications, to prescribe drugs, to do even minor surgery or to be admitted to the local municipal or voluntary hospital. It is fortunate that many mothers have been educated to select care wisely, by the continuous and vigorous efforts of many organizations, including the federal Children's Bureau, with its famous and popular booklets, "Prenatal Care" and "Infant Care."

Congressman Walter H. Judd of Minnesota, voicing strong opposition to the enactment of this amendment, declared: "The argument is made that, after all, this is a matter for the states to decide; and if certain states license individuals with lesser training to practice obstetrics, who are we to say who shall practice obstetrics within their jurisdiction? It is an argument with which I concur wholeheartedly, except under two conditions: first, when the standards in the states are reasonably uniform. Such is not the case in this instance. The chief objection is not to those states which have laws requiring the passage of examinations in the basic sciences and require that men or women, to be permitted to practice obstetrics in the state, shall serve proper internships and demonstrate that they possess high-grade qualifications in the handling of abnormal as well as normal obstetrical cases.

"The great danger we see in this provision comes from those states which have low standards, where almost any good-hearted mammy who believes that she is called of God to take care of women in childbirth is licensed to go out and do so. We feel that it is most dangerous for a provision like this to be slipped through without careful consideration or debate, and without recognizing what it does to the high standards which have been worked out very carefully by the medical profession all during these years.

"Objection can be raised that so many doctors are now in the service, that it is not possible to get obstetrical care unless in some states men and women with lower standards of training are used. It is true that in most obstetrical cases if the attendant merely exercises masterful inactivity and knows enough not to intervene, nature will take care of itself. But the test comes when things do not proceed normally. When to intervene, what needs to be done, how to do it—in no emergency of medicine or surgery is better judgment and more skill needed.

"For example, the individual who is able to handle normal obstetrics satisfactorily meets a situation where a cesarean section is necessary to save the woman's and the child's life. He is not qualified or licensed to do major surgery. It is natural for him to try, as long as he can, to use the method that he or she is accustomed to. He is likely not to recognize in time his own limitations. He does not like to confess his own inadequacy and call in a doctor who is adequately trained. He may delay until the woman's life cannot be saved nor the child's. All these years we have worked to lower the infant and maternal mortality throughout the country and with spectacular results. Here we are doing a thing which is bound to increase the mortality rate in many States."

The Foot in the Door?

The congressmen who advocated the amendment made it quite clear that it applied only to obstetric care, not to the care of crippled children or to the other phases of the program of the Children's Bureau, but it is poor logic to require under law that crippled children must be cared for by practitioners with the highest qualifications and experience, but to permit babies to be delivered and cared for by these so-called cultists. A large percentage of crippling occurs at birth, and this is due chiefly to poor medical care. There just is not any sense to it unless this is only a first step to let down the bars for all kinds of medical care. It may be the foot in the door. It is a bad precedent and one which must be fought by all those who are interested in maintaining high standards of care throughout this land.

The amendment tends to cause confusion rather than to simplify matters. Even on the floor of Congress there was sharp disagreement of opinion as to whether states permitting midwives and chiropractors to care for mothers actually licensed them or not. This clause does not differentiate between those who know their business and those who do not. Undoubtedly, some osteopaths, graduates of recognized schools, can and do provide safe obstetric care, but there are others called by the same name who are merely graduates of the old diploma mills and who have no experience and no training in this field.

This new amendment makes no discrimination between the good and the bad, the sheep, and the goats. It is not wise legislation nor sound social policy. We cannot permit the health and well-being, the strength and vigor of our next generation to be tampered with by the lobbyists of any pressure group in Washington, and no doubt this law is the result of clever and powerful manipulation. This is the time to nip bad precedents in the bud.—Mrs. Shepard Krech, President, Maternity Center Association, in *Briefs*, publication of the Maternity Center Association, 654 Madison Avenue, New York, 21.

ITEM XXVI: MATERNITY–PEDIATRIC

Best Medical Care for Service Men—Second-Rate Care for Their Wives and Babies: Statements by Members of Congress

The armed services insist on the best medical care for the men on the fighting fronts and in the training camps. They will not commission osteopaths, chiropractors, naturopaths, and their kith and kin, as medical officers. Dr. James C. Magee, former Surgeon-General of the Army declared, "The citizens of this country who give their sons to the military service have every right to expect that they will receive the highest type of medical attention when they are sick or wounded. In order to carry this out, it is imperative that only those physicians whose training has been based upon sound, scientific principles can be utilized in their care." This has been reiterated by his successor, Surgeon-General Kirk.

Certainly, the same high quality of care should be provided to the wives of these men, who are often facing hard times at home because their husbands are away. They will have to be mother and father to their baby, and they need all the strength and health that they can muster to do the job right.

Senator Robert LaFollette of Wisconsin made it quite clear where he stands on this matter: "I want no father of a child born while the father is overseas fighting for his country to point his finger at me and say, 'You are responsible for the death of my wife and child in my absence, because a man was permitted to minister to her at her time of need who was not properly equipped, who was not licensed to use drugs, who was not licensed to practice surgery.'

"Under the present law, the Children's Bureau has the right to set standards for persons who are eligible to be paid out of federal monies so far as this program is concerned. Personally, I believe that the dearth of physicians and surgeons has been seized upon as a means of striking down the standards which have been established. I am satisfied that those who are administering the program are just as determined as is anyone else to see that women are afforded proper service, and they will see that they get it. I don't think there is a scintilla of evidence before either of the committees to show that any person eligible for obstetrical care under this program has been denied proper care because of these standards. There has been considerable general talk about the scarcity of physicians, which everyone knows is true; but, so far as I know, not one scintilla or shred of evidence has been presented to show that because of the high standards required any service has been denied to any woman eligible for it.

"I say that to yield on this matter is a step backward in modern practice of obstetrics, and it is unfair to the service men, who are preparing to give their lives for their country, if necessary, that their wives, who are pregnant and who are to be delivered in their absence, shall not have the benefit of the finest standards and the finest care that money can procure.

"Yet, in this false application of the so-called doctrine of states' rights, such a situation will be created that the Congress will have done that very thing. So far as I am concerned, I want no part of it."

Representative I. D. Fenton of Pennsylvania, on the floor of the House commented: "The action taken here today will permit those people who are not recognized in regular medicine to deliver babies of the wives of our soldiers. Our military authorities refuse to grant these same people the right to receive commissions in the Army to administer to the boys while they are in service. Now they are going to permit them to go out in the general practice of medicine and to try to deliver the babies of the wives of these boys who are in the Army. I think we are taking a step backward."

Thus, we find that this harmless-appearing amendment enacted in the hustle and bustle of the days before the Congressional summer recess, can and will bring needless suffering and death to the wives and children of the men now fighting our battles in Sicily, Europe, Asia, Africa, and the islands of the South Seas.—From *Briefs*, publication of the Maternity Center Association, 654 Madison Avenue, New York, 21.

* * *

"APPROPRIATION BILL NO PLACE FOR SUCH AN AMENDMENT"—CHANDLER

"In my opinion, the provision in question would do irreparable harm to the services performed by the Children's Bureau, and their fine work in saving the lives of little children. It is my definite conviction that it will cause very great harm to child welfare work in the states, and to the state health bureaus, and that same bill should be passed forthwith to clarify the situation. It should be handled carefully, after public hearings, and with a clear understanding of the problem. An appropriation bill is not the place for such a provision."—Senator Albert B. Chandler of Kentucky.

* * *

"A HARMFUL AMENDMENT"—LODGE

Said Senator Henry Cabot Lodge, Jr., of Massachusetts, on the floor of the Senate: "The effect of the amendment is to make it possible for child-bearing women who are treated under the provisions of the Act to have the services not only of obstetricians and of osteopaths, but of chiropractors and midwives.

"I fully appreciate the place of these various practitioners in our scheme of things, and I am saying nothing whatsoever in criticism of them. In general, I will be found to be a believer in the rights of the states and opposed to trespassing on them; but I submit that in cases where federal funds are being employed, the Federal Government has a right to impose the precept or standard without being accused of violating the rights of the states.

"In this particular case the Children's Bureau desires to give the women who need care the very best possible care.

"There is no question here about denying to any woman the right to have any kind of medical care she wants with her own money, but when we are administering a federal program, with federal funds, I believe the same federal standard that is complied with in regard to medical care in every other branch of the federal service which concerns itself with medical care should be applied to the women of the nation, and to the wives of the soldiers. In my opinion, it would not be right to expose them to a degree of medical care which is inferior to that which is received by their husbands.

"I am very sorry the amendment was agreed to . . . I merely want the Record to show that I believe this is a harmful amendment in the form in which it is now written."

* * *

AMENDMENT HINDERS STATE ADMINISTRATION SAYS FORMER STATE HEALTH OFFICER—CONGRESSMAN MILLER

Dr. A. I. Miller, Congressman from Nebraska and former State Health Director, put it this way: "I want to say to the House that this amendment, if it is left in the bill, will hinder the administration of the funds in a manner which is unwise.

"There are many States in which individuals are permitted to take care of obstetrical cases, but where they are not permitted to perform certain acts, like the administration of hypodermics or the repair of lacerations. It is a question of deciding if this House wants quantity of care or quality of care for the wives of our soldiers. In the practice of surgery and in the practice of obstetrics, many new things have been discovered in the last quarter of a century. There are many medicines that are being used today by men who have qualified to take care of women who are having babies that were not used a few years ago.

"If you adopt this amendment, it will make it impossible for the Children's Bureau or the health directors in many of the states to use the funds and give these women who are going to have babies the type and quality of care you would want your daughter or your neighbor's daughter to have. . . . You are, in effect, keeping future mothers from getting the quality of care they should have."

ITEM XXVII: MATERNITY–PEDIATRIC

Malpractice Liability: Re Services to Wives of Enlisted Men

(COPY)

San Francisco, September 15, 1943.

Dear Doctor:

This will acknowledge receipt of your letter of September 11, 1943, relative to malpractice liability of physicians rendering medical services to wives of enlisted men in the armed forces during pregnancy. You advise in your letter that such services are rendered under a program administered by the State Board of Health under authorization from the Federal Government.

In my opinion, the status of a physician rendering services under this program and being paid by the State of California is similar to physicians who render services, gratuitous or compensated, in county hospitals and similar institutions. Generally speaking, physicians who render professional services on behalf of a state, county, or municipality are considered to be public officers and the rules of law applicable to public officers in general are applied to them in determining their rights and liabilities.

The rule is stated in *21 California Jurisprudence* at page 908:

"It is elemental that a public officer is liable to respond in damages to one specially injured by his neglect or refusal to perform or by his negligent performance of an official ministerial duty to the extent of such special injury, regardless of intentions, whether good or bad."

The courts have uniformly held that neither the state nor the county is liable for the malpractice of a physician or surgeon employed by the state or county, but that *the physician himself is liable* in every respect in the same manner as a physician who is engaged in private practice and renders professional services to his own private patients. It has long been established law that the fact that a physician or surgeon who renders his services gratuitously does not absolve him from the duty to use reasonable and ordinary care, skill, and diligence. There are many instances where physicians or surgeons have been charged with liability for malpractice on account of services donated in the county hospitals and similar institutions.

Accordingly, it is my opinion that, in rendering professional services under the federal program referred to in your letter, you would be subject to liability for malpractice to the same extent and under the same conditions as in the case of your private patients.

In cases such as this the courts base their decision upon the premise that the fact that a physician is rendering his services gratuitously or at a reduced fee does not absolve him from the duty to use reasonable care.

Very truly yours,

(Signed) HARTLEY F. PEART

ITEM XXVIII: MATERNITY–PEDIATRIC

Soldiers' Babies

Local physicians, like medical men all over the state and nation, are "in a spot" regarding the federal program to provide care for wives of noncommissioned service men when they are having their babies. The doctors are in entire accord with the principle involved, for they recognize that these young men are ill-paid, that the coming of a baby always entails considerable expense, and that in thousands of cases the young mother has to go through her ordeal with her husband thousands of miles away. In such instances a little federal money would be a godsend.

The physicians recognize these things, yet, as was stated at a meeting of the Santa Clara County Medical Society this week, they are opposed to having the Government set the fees for their services, which is what happens as the system is now set up.

Socialized medicine is the fear and bugaboo of nearly all American physicians. They know that certain elements in the Administration favor it strongly. They have seen how badly it has worked in some countries in Europe. They feel, in all honesty and sincerity, that the public is less likely to get competent and conscientious care under a system of socialized medicine.

Most physicians recognize that the present system here in America is not perfect and that the very rich and very poor tend to get good care, while the vast middle class find illness a pretty hard financial burden. Most medical organizations are trying to do something about this situation. They are afraid, however, of wholesale control of medicine by the Government, just as a lot of other people in other lines are afraid of wholesale federal control.

In regard to this problem of providing Government aid for wives and babies of service men, the problem of the physicians is to make it plain that they endorse the principle, but dislike the present method. Instead of having the Government set fees and charges, they think the money should be paid to the mother, who would thereupon apply it to hospital and medical costs, as she desires.

So far as the mother and baby are concerned, the result would be the same. So far as the American medical profession is concerned, the revised plan would preserve one more angle of their business from federal control.—Editorial in San Jose *News*, September 18.

ITEM XXIX: MATERNITY–PEDIATRIC

Federal Children's Bureau Plan: Resolutions of Component County Medical Societies in California (Santa Clara, Sacramento, Solano, Contra Costa and Yolo)

RESOLUTION ADOPTED BY SANTA CLARA COUNTY MEDICAL SOCIETY

September 9, 1943

Philip K. Gilman, M. D.
Chairman of the Council

Re: Plan of Federal Children's Bureau to Provide Obstetric and Pediatric Care for Wives and Infants of Enlisted Men.

Dear Doctor Gilman:

At the meeting of the Council of the Santa Clara County Medical Society held September 8, 1943, the above subject was thoroughly discussed.

The Council was unanimous in approving the stand taken by the California Medical Association regarding this matter.

(Signed) John Hunt Shephard, M. D.,
Secretary, Santa Clara County Medical Society.

* * *

RESOLUTION ADOPTED BY SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT

Whereas, At a special meeting of the Board of Directors of the Sacramento Society for Medical Improvement held on August 18, 1943, the following resolution was passed:

Whereas, The Board of Directors of the Sacramento Society for Medical Improvement approves in principle the federal Children's Bureau plan for maternity and infant care for wives and children of certain groups of enlisted men; and

Whereas, They are strenuously opposed to the procedure proposed in this plan which forces a physician to contract with the Federal Government for both medical services and hospitalization at certain fixed fees, and feel that an amplification of the above method will eventually lead to the socialization of medicine with a consequent lowering of the standards of medical care; therefore, be it

Resolved, That the Council of the California Medical Association be requested to reconsider this entire plan and provide state wide leadership in order that a cash allotment to the patient be substituted for the present method; be it further

Resolved, That failure to obtain active progress in the removal of the objectionable features of this plan within ninety days will lead to the withdrawal of coöperation by the Sacramento Society for Medical Improvement.

* * *

RESOLUTION ADOPTED BY THE SOLANO COUNTY MEDICAL SOCIETY

Whereas, The resolution of the Board of Directors of the Sacramento Society for Medical Improvement was on September 14, 1943, presented to the membership of the Solano County Medical Society at a regular meeting of that society; and

Whereas, The members of the Solano County Medical Society heartily approve of the above resolution; therefore, be it

Resolved, That the Solano County Medical Society unanimously endorse the aforesaid action of the Board of Directors of the Sacramento Society for Medical Improvement; and be it further

Resolved, That failure to obtain active progress in the removal of the objectionable features of this plan within ninety days will lead to the withdrawal of coöperation by the Solano County Medical Society.

* * *

RESOLUTION ADOPTED BY CONTRA COSTA COUNTY MEDICAL SOCIETY

Whereas, The Contra Costa County Medical Society approves in principle the federal Children's Bureau plan for maternity and infant care for wives and children of certain groups of enlisted men; and

Whereas, They are strenuously opposed to the procedure proposed in this plan which forces a physician to contract with the Federal Government for both medical services and hospitalization at certain fixed fees, and feel that an amplification of the above method will eventually lead to the socialization of medicine with a consequent lowering of the standards of medical care; therefore, be it

Resolved, That the Council of the California Medical Association be requested to reconsider this entire plan and provide state-wide leadership in order that a cash allotment to the patient be substituted for the present method; and be it, therefore,

Resolved, That failure to obtain active progress in the removal of the objectionable features of this plan within ninety days will lead to the withdrawal of coöperation by the Contra Costa County Medical Society.

* * *

RESOLUTION ADOPTED BY YOLO COUNTY MEDICAL SOCIETY

Whereas, The Yolo County Medical Society approves in principle the federal Children's Bureau plan for maternity and infant care to the wives and children of certain groups of enlisted men; and

Whereas, They are strenuously opposed to the procedure proposed in this plan which forces the physician to contract with the Federal Government for both medical services and hospitalization at certain fixed fees and the enormous amount of paper work and potential delay in payments that will be demanded; be it

Resolved, That the Council of the California Medical Association be requested to take a definite stand as regards this entire plan and provide state-wide leadership in order that a cash allotment to the patient be substituted for the present method.

ITEM XXX: MATERNITY–PEDIATRIC

Maternity and Infant Care by United States To Be Resumed in California

The Government will continue to take care of emergency maternity and infant care cases of wives of service men, Dr. Wilton L. Halverson, State Department of Health director, announced today.

This service, suspended on September 15 because of lack of funds, will be resumed here and in thirty-four other counties, Doctor Halverson said. His department has been assured of an immediate grant of $461,606 to pay for the individual care of individuals whose applications have been approved and to provide care through this month.

"The United States Children's Bureau has been notified that, due to the large number of service men's wives living in California and the high cost of medical care here, an estimated four million dollars will be required to carry the program in this state through the 1943-44 fiscal year," declared Doctor Halverson.

(A new congressional appropriation of $18,600,000 for this purpose has been set up.)

Any woman, irrespective of her legal residence, whose husband is an enlisted man in the Fourth, Fifth, Sixth, or Seventh grades in the Army, Navy, Marine Corps or Coast Guard, is eligible under the program for medical and hospital maternity care without cost.

Care is provided throughout pregnancy and for six weeks after delivery as well as at confinement. Any infant under a year whose father is a service man in these grades is also entitled to care for serious illness.

"Spread of the program to the rest of the counties is awaiting completion of satisfactory arrangements with local health departments, physicians, and hospitals," Doctor Halverson concluded. "Payment for care is made on a cost basis by health departments administering the program."—San Francisco *News*, October 2.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

War-Time Nursing

(COPY)

WAR MANPOWER COMMISSION

Washington 25, D. C.,
September 1, 1943.

California and Western Medicine,
Addressed.

The attached statement has been issued by the Directing Board of War Manpower Commission's Procurement and Assignment Service for physicians, dentists, veterinarians, sanitary engineers, and nurses.

The Directing Board would appreciate your coöperation in calling to the attention of members of your profession the important problems discussed in the statement.

* * *

WARTIME NURSING IS DIFFERENT

It is utterly impossible to provide the necessary volume of wartime nursing service on a peacetime basis. Places where nursing is going on as usual must share with others. Individual nurses who have not made adjustments to wartime needs for their service should understand the necessity for their participation.

The National Nursing Council has pointed out that the value of any national plan must be judged by its usefulness at the local level, *i. e.*, where nurses live and work—in the country, in the villages, towns, and cities of the nation.

Wartime nursing is different. That inescapable fact must be generally accepted by nurses, by physicians, and by hospital administrators. Energy and motion now spent in resistance to change must be released for the attack on war-created needs.

Nurses have wrought many changes, but not enough, in the pattern of nursing service since Pearl Harbor. . . .

The principles of good nursing have not changed, but nurses are learning to concentrate on the essentials. . . .

A critical shortage of nurses exists. Here are the facts:

Over 36,000 nurses are now with the armed forces, and the Red Cross has accepted responsibility for the recruitment of an equal number by June 30, 1944. Our men are receiving skilled medical care of a high order, as shown by the high percentage of recovery from injury. Skilled nursing is an important factor in such care. Then, too, the very presence of nurses near the bases of military operations has repeatedly been described as a potent force in maintaining morale.

There has been an unprecedented increase in the use of civilian hospitals. Hospitals gave fourteen and a quarter million more days of care in 1942 than in the preceding year and the trend still is definitely upward. . . .

Nursing is essential to the nation's health. The National Nursing Inventories (of nursing resources) of 1941 and 1943, by the United States Public Health Service, offer a comparison of data for the two years. See Table 1.

The total number of nurses graduated in the two years is well in excess of the number withdrawn for military service; this fact is not apparent in the inventory. . . .

The relatively small decrease in the number of institutional nurses is much less significant than the increased use of hospitals in creating the serious shortage of nurses. The increased number of nurses in industrial nursing is, of course, not surprising. . . .

Through the War Manpower Commission, nursing will not only have the benefit of the experience of medicine in the procurement and assignment of physicians, but means will be found to interpret wartime nursing to physicians and their coöperation secured in effecting desirable wartime adjustments.

REFERENCES

Priorities for Nurses. National Nursing Council for War Service, 1790 Broadway, New York, N. Y., May, 1943. Revised edition.

Distribution of Nursing Service During War. National Nursing Council for War Service, 1790 Broadway, New York, N. Y., 1942.

Volunteers in Health. Medical Care, and Nursing. U. S. Office of Civilian Defense, Washington, D. C.

TABLE 1.—*National Nursing Inventories*

	1941	*1943*
Total returns	289,286	259,174
Active		
Institutional	81,708	77,704
Public Health	17,766	18,900
Industrial	5,512	11,220
Private duty	46,793	44,299
Other	21,276	18,476
Inactive, but available for nursing	25,252	38,746 (of these 23,576 are married and under 40)
Inactive, not available	90,979	49,829
In Nurse Corps of Army and Navy	6,371	over 36,000 (precise data not available)

COMMITTEE ON POSTGRADUATE ACTIVITIES†

CALIFORNIA HEART ASSOCIATION

Meetings to Be Held in San Francisco, Los Angeles, and San Diego

Dr. Tinsley R. Harrison, Professor of Medicine at the Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, North Carolina, will be the guest speaker at the symposia on heart disease to be held under the auspices of the California Heart Association. Doctor Harrison is one of the outstanding internists in the United States. His work on the mechanism of the circulation, given to the medical profession in his book, "The Failure of the Circulation," is a notable contribution to cardiology.

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† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

The meetings will be held on these dates:

San Francisco—November 4, 5, and 6.
Los Angeles—November 11 and 12.
San Diego—November 9 (dinner meeting only).

* * *

San Francisco Heart Committee

Thursday Morning, November 4, 1943

9:30 a.m., to 12 noon

Stanford University Medical School, Stanford Hospital
Lane Hall, Sacramento Street, near Webster

David R. Rytand, M. D., Presiding

Considerations of Anemia with Heart Disease, Robert S. Evans, M. D.

Coexistence of Rheumatic Heart Disease and Glomerulonephritis, Ann Purdy, M. D.

Hypercholesterolemia in Coronary Artery Disease, J. K. Lewis, M. D.

The Abuse of Rest in the Treatment of Cardiovascular Disease, Tinsley R. Harrison, M. D.

Thursday Afternoon, November 4, 1943

1:30 p.m. to 4:30 p.m.

Stanford University Medical School, Stanford Hospital
Lane Hall, Sacramento Street, near Webster

Clinical-Pathological Conference, Tinsley R. Harrison, M. D., and Alvin J. Cox, Jr., M. D.

Diagnostic Value of X-Ray in Certain Types of Heart Disease, James B. Irwin, M. D.

Masked Hyperthyroidism with Heart Disease, Lester S. Lipsitch, M. D.

The Relationship of Hypertension to Arteriosclerotic Heart Disease, Arthur Selzer, M. D.

The Heart in Obesity, David A. Rytand, M. D.

Friday Morning, November 5, 1943

9 a.m. to 12 noon

University of California Hospital, Toland Hall
Third and Parnassus Avenues

Dr. Leslie Bennett, Presiding

9:00 a.m.—*Rheumatic Fever, 1943,* Lt. Comdr. Harold Rosenblum, M.C., U.S.N.R.

9:30 a.m.—*Aids to the Physician in the Convalescent Care of Rheumatic Fever Patients,* Miss Ethel Cohen.

9:45 a.m.—*A Restudy of One Thousand Men Rejected by Selective Service for Alleged Cardiovascular Disease,* Dr. William J. Kerr representing the Board, consisting of Doctors Edwin L. Bruck, Francis L. Chamberlain, Paul A. Gliebe, J. K. Lewis, E. R. Miller, J. Marion Read, David Rytand, John J. Sampson, Mayo H. Soley.

10:15 a.m.—*Recess.*

10:25 a.m.—*The Smithwick Splanchnicectomy for Essential Hypertension,* Dr. Howard C. Naffziger.

11:00 a.m.—*Gostro-Intestinal Disorders Simulating Angina Pectoris,* Dr. Tinsley Harrison.

Friday Afternoon, November 5, 1943

University of California Hospital, Toland Hall
Third and Parnassus Avenues

A Symposium on Therapy, Dr. W. J. Kerr, Presiding
(To run concurrently with program below in Room 437)

1:30 p.m.—*The Management of the Patient with Cardiac Arrhythmia,* Dr. Francis Chamberlain.

2:20 p.m.—*The Management of the Patient with Congestive Failure,* Dr. Charles Noble.

3:10 p.m.—*The Management of the Patient with Coronary Artery Disease,* Dr. W. J. Kerr.

4:00 p.m.—*Some Common Errors in Interpretation of Electrocardiograms as Indicating Coronary Artery Disease,* Dr. Tinsley Harrison.

* * *

University of California, Room 437
Out-Patient Department

Dr. Leslie Bennett, Presiding

(To run concurrently with program above in Toland Hall)

1:30 p.m.—*The Management of the Patient with Hypertensive Heart Disease,* Dr. Leslie Bennett.

2:20 p.m.—*The Management of the Pregnant Woman with Heart Disease,* Dr. Ellen Brown.

3:10 p.m.—*The Management of the Patient with Luetic Heart Disease,* Dr. Paul Aggeler.

Friday Evening, November 5, 1943

8 p.m. to 10:15 p.m.

San Francisco County Medical Society
2180 Washington Street, at Laguna

Francis L. Chamberlain, M. D., Presiding

The Present Status of Research in Hypertension, Tinsley R. Harrison, M. D.

Round-Table Discussion of Questions Submitted by Registrants—Drs. Arthur L. Bloomfield, Francis L. Chamberlain, Tinsley R. Harrison, William J. Kerr, J. K. Lewis.

Election of Officers.

Beer and sandwiches.

Saturday Morning, November 6, 1943

9 a.m. to 12 noon

San Francisco Hospital

Potrero Avenue and Twenty-Second Street

(Report at Main Entrance of Hospital)

Charles A. Noble, Jr., M. D., and J. Marion Read, M. D., Presiding

Clinical Demonstration of Various Types of Heart Disease.

Doctors will rotate through wards in small groups to facilitate discussion and examinations including electrocardiography and x-ray films.

Participants:

Stanford University—George De F. Barnett, Walter Beckh, Lovell Langstroth, J. K. Lewis, Lester S. Lipsitch, Arthur Selzer.

University of California—Henry Brainerd, LeRoy H. Briggs, Edwin S. Bruck, Jesse L. Carr, Don G. Gardner, Allen T. Hinman.

Thirteenth Annual Symposium of the Los Angeles Heart Association

Thursday, November 11, and Friday, November 12, 1943.

Guest Speaker: Tinsley R. Harrison, Professor of Medicine, The Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, North Carolina.

Officers of the Association: Louis E. Martin, President; Wilbur A. Beckett, Vice-President; William Paul Thompson, Secretary-Treasurer.

Thursday, November 11

10 a.m. to 12 noon

Main Auditorium, First Floor, Los Angeles
County Hospital, 1200 North State Street

A Cardiac Clinic—Tinsley R. Harrison, M. D., Winston-Salem, North Carolina.

Thursday, November 11

2 to 5 p.m.

Headquarters of the Los Angeles County Medical
Association, 1925 Wilshire Boulevard

The Practical Management of Patients with Hypertension, W. Gordon Garnett, M. D., Los Angeles.

The Diagnosis of Rheumatic Fever in Children, S. J. McClendon, M. D., San Diego.

On the Importance of Speaking One Heart Language, Wilbur A. Beckett, M. D., Los Angeles.

The Importance of Salt and Fluids in the Treatment of Congestive Heart Failure, Francis M. Smith, M. D., La Jolla.

Cardiovascular Disease in an Army General Hospital, Major Maurice Eliaser, Jr., M. C., Chief, Cardiovascular-Renal Section, Hoff General Hospital, Santa Barbara.

The Treatment of Cerebral Vascular Accidents, Leon G. Campbell, M. D., Pasadena.

Thursday, November 11

7 p.m.

Annual Dinner, California Club, 538 South Flower Street, Cocktails will be served at 6:30 p.m.

The Abuse of Rest in the Treatment of Cardiovascular Disease, Tinsley R. Harrison, M. D., Winston-Salem.

Friday, November 12

9:30 a.m. to 12 noon

Headquarters of the Los Angeles County Medical
Association, 1925 Wilshire Boulevard

The Critical Diagnosis of Angina Pectoris, Donald E. Griggs, M. D., Los Angeles.

The Importance of the Electrocardiogram in Coronary Artery Disease, Edward C. Rosenow, Jr., M. D., Pasadena.

The Place of the Radiologist in the Diagnosis and Treatment of Heart Disease, Wilbur Bailey, M. D., Los Angeles.

One Thousand Draft Rejections for Cardiovascular Conditions, William J. Kerr, M. D., Professor of Medicine, University of California Medical School, San Francisco.

The Differential Diagnosis of Palpitation, Tinsley R. Harrison, M. D., Winston-Salem.

Friday, November 12

2 to 5 p.m.

Headquarters of the Los Angeles County Medical Association, 1925 Wilshire Boulevard

Nutritional Considerations in Heart Disease, Howard F. West, M. D., Los Angeles.

The Treatment of Cardiovascular Syphilis, C. Russell Anderson, M. D., Los Angeles.

The Patient with Diabetes and Heart Disease, Kendrick Smith, M. D., Los Angeles.

The Need for Conservatism in the Treatment of Acute Coronary Occlusion, J. Philip Sampson, M. D., Santa Monica.

A Clinical-Pathological Conference: Two Cases, Tinsley R. Harrison, M. D., Winston-Salem, and Alvin G. Foord, M. D., Pasadena.

Business Meeting. Election of Officers.

* * *

A fee of $10 will be charged. This includes admission to the symposium, annual dinner, membership in the Los Angeles and California Heart Associations, and annual subscription to "Modern Concepts of Cardiovascular Disease." Physicians in military service, interns, and residents will be admitted without charge, but a charge of $4 will be made for the dinner. The charge for guests at the dinner is $4. Admission to the symposium and the dinner will be by ticket. The Association regrets that it cannot accept requests for dinner reservations later than Monday, November 8. Tickets will be held at the registration desk, where they will be delivered to those whose applications and remittances have been received on or before November 8. Applications should be mailed to Dr. William Paul Thompson, Los Angeles Heart Association, 122 East Seventh Street, Los Angeles, 14.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Wagner-Murray-Dingell Bill (S. 1161) and United States Public Health Service

(*Surgeon-General Parran's Letter Thereon*)

(copy)

Bethesda (14) Station

July 17, 1943

Mr. Kenneth C. Crain:
V. P.-Eastern Editor
"Hospital Management"
330 West Forty-Second Street
New York, 18, N. Y.

Dear Mr. Crain:

This will acknowledge your letter of June 28 in which you ask for information about the plans of the Public Health Service for a medical care and hospitalization program to be developed along the lines proposed in the Wagner-Murray-Dingell Bill.

At the time Senator Wagner introduced the bill he stated the legislation was sponsored by the American Federation of Labor. Whatever its origin, it is not an Administration bill, and I did not see it before it was introduced. The Public Health Service has as yet developed no plans for a comprehensive medical care or hospitalization program. Indeed, implementation of the provisions of the bill at this time would appear to be difficult, if not impossible, in the face of existing and increasing shortages of medical personnel and of materials for the construction of additional health facilities.

As you can readily appreciate, my immediate concern is with urgent health needs in communities affected by the war either directly or indirectly. Considerable difficulty has been encountered in constructing even the few hospitals and hospital additions which are absolutely essential to serve the increased population in war industry and extra cantonment areas. The withdrawal of physicians from communities which never did have adequate medical services has created another problem, as has the shortage of nurses.

Thus, our efforts for the present must be directed mainly toward emergency activities dictated by the war. Yet we cannot shut our eyes to the long-time health needs of the country nor can we wait until the war is over before considering ways in which the needs should be met. Proposals for national health programs are being advanced in several countries, notably Great Britain, Canada, Australia, and New Zealand. In this country, too, there is a revival of interest in some form of concerted action to bring out a more equitable distribution of health services and facilities after the war.

If and when a new health program is developed in this country, I think it will come as a result of free and open discussion of principles, objectives, and methods of implementation. The subject is highly controversial, as you have indicated, yet I believe we could avoid much of the bitterness that has delayed progress in other countries and has set at cross purposes those who should be working for the common good.

Personally, I have no cut-and-dried plans about the pattern to be followed in developing a comprehensive program—assuming one to be feasible financially and administratively in the near future. I think we would all agree that health services should be available to everyone and that the Government has a responsibility for the health of the people. I believe, too, that much greater emphasis should be placed on preventive medicine in community health activities and in the care of individuals and that present artificial barriers between prevention and cure should be broken down, not strengthened. At this time I do not see how we can go much beyond these general statements, for further discussion will be necessary before any commitments can be made. In approaching this whole broad problem there will be need for mutual trust and coöperation, freely given by public and private agencies alike, by professional and lay organizations, and by all groups and persons sincerely devoted to the advancement of health.

I greatly appreciate the interest you have shown in the work of the United States Public Health Service.

Sincerely yours,

Thomas A. Parran,
Surgeon-General.

Chester Rowell: Bugaboo Arguments on Health Insurance*

(copy)

Somebody sends a reprint of a letter from a letter from a Chicago correspondent to the *Christian Science Monitor* quoting medical, not Christian Science, objections to an alleged "Wagner-Murray" bill said to be before Congress which, under the guise of sickness insurance, has for its real purpose the destruction of "free economy" and the "complete bureaucratic domination of the American people," and the reduction of the doctors to "abject slavery." Incidentally, "the cost of the individual family head would average $120 a year," or a total to the United States of over three billions.

If the arguments were Christian Science ones, made by the church or by the *Monitor* on its behalf, they would be entitled to the most serious consideration. Many of those who prefer to be treated by Christian Science practitioners argue not merely that they should not be required to accept the undesired services of medical practitioners, but also that they should not have to pay, directly or indirectly, for such service. If this were a plea, on their behalf, for exemption on this ground, almost any committee on the subject would be glad to confer with their representatives, to see if a feasible plan to meet this situation could be agreed on.

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* For editorial comment, see page 208.

However, those who do not wish medical care for themselves are now paying their share toward providing it for others who do wish it, and we have not heard that they object. They pay taxes to support hospitals and clinics, and to provide medical services and drugs for the indigent. They pay the same taxes as others for the vast cost of the army medical service, and if they are wounded or stricken with disease while themselves serving in the armed forces, they are treated by Army or Navy surgeons. Their employers pay directly (and they indirectly) under workmen's compensation for surgical and hospital care, and even for something toward the cost of rent and food, if they are injured in their work. If their share of the general cost of health insurance were also charged against their wages, it would be rather the extension of an old principle than the imposition of a new one.

But all this has nothing to do with the immediate publicity, which is all quoted from one John M. Pratt, "executive administrator" (in other words, publicity agent) of the "National Physicians' Committee." And his arguments—like those of nearly all the other press agents mistakenly employed for this purpose—consist of slogans and epithets against nonexistent bugaboos.

We have not seen the text of this alleged sickness insurance bill, but if it even remotely resembles the account of it quoted from Mr. Pratt, it could scarcely receive a single vote in Congress and would certainly be repudiated by every informed supporter of health insurance. There were no such provisions in a single health insurance system in the world in the days before the war when every civilized country except the United States had such a system, and this writer at least, who has for fifty years been urging the adoption of health insurance by American States, never heard of any such proposal here—except in the bugaboo publicity of paid lobbyists.

The chief bugaboo, of course, is the phrase "State medicine," which is exactly what legitimate health insurance aims to prevent. We do have State medicine, to be sure, in the Army—where, incidentally, it is the best medical service in the world. Army surgeons are all salaried men, and the wounded soldier does not choose which one will operate on him, nor pay him for doing it. The service in county hospitals for those who cannot pay is also State medicine. And the care of disabled soldiers after the war will be on the same system. We may get more State medicine after the war, as a result of the radical changes which it may produce, even in civil life. But not by reason of the adoption of real health insurance if that comes.

There is room here for only one more bugaboo, which is cost and dictatorship. According to Mr. Pratt's committee, the Surgeon-General of the United States would be its dictator. He would have $3,048,000,000, which would enable him to hire every hospital bed, public and private, in the United States; to hire all its physicians, at $5,000 a year each; and to spend $168,000,000 a year for drugs and $600,000,000 for administrative costs. In addition, he would pay the total cost of operating the medical colleges of the United States, support all the medical students during their courses, and spend $11,000,000 a year on research. And he could get all this staggering sum by the simple bookkeeping entry of transferring it from the Federal Social Insurance trust fund, where it supposedly now is, so that "the cost to the individual family head" of $120 a year would actually cost nobody anything.

"The Committee reports that it is getting an enthusiastic response from many of those to whom it has sent its literature, including 131,000 doctors."

No wonder, if they believe the guff this press agent sends them!

Here, however, is one of them who, like the gentleman from Missouri, waits to be "shown." — San Francisco *Chronicle*, September 7.

Shenanigans of the Medical Trust

(Opinion of a Labor Group)

Some who imagine that the American Medical Association is the sanctified repository of science and who raise an eyebrow when we mention the "medical trust," might be slightly disillusioned by the article we published on Monday, exposing the American Medical Association's attempt to prevent even the mild Social Security measure of the Wagner-Murray-Dingell Bill from passing Congress.

More particularly, the "front" organization of the American Medical Association, going under the high-sounding title of "The National Physicians' Committee for the Extension of Medical Service," is exposed as spending thousands of dollars for propaganda against the bill, propaganda which uses the phraseology of all American Fascists in attacking all social reform.

The attack centers upon the health provisions of the Social Security bill, which is called "totalitarian," "regimentation," and "political medicine," while the present shameful lack of adequate medical care to the bulk of the people, a lack which is responsible for the huge percentage of rejections for disability of draftees by the armed services, is termed—"the Christian concept of the sanctity of human personality—the American way."

Under the health provisions of the bill, known as "Senate Bill 1161," the United States Surgeon-General is empowered to obtain volunteer physicians to work under the health insurance sections of the Act, to arrange for hospitalization and set fees to be paid for work done by doctors. This is the special target of the American Medical Association, which sees the "menace" of an "attempt to abolish private medical practice," though a large proportion, if not a majority, of physicians are eager to extend such medical service and would be materially benefited by it.

The point of all this is that the American Medical Association is engaging in a campaign to kill Senate Bill 1161, by urging all physicians to incite protest locally, to get local Chambers of Commerce and civic bodies to oppose the bill.

The people should be on the lookout for this propaganda, and particularly note that physicians are urged to "try to have your local newspapers carry a story and/or editorial" against Senate Bill 1161.

The people also should take a positive stand in support of Senate Bill 1161, and urge all Congressmen to vote for it.—San Francisco *People's World*, August 26.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Kaiser Steel Mill at Fontana, California, Opens New Hospital

Built and designed to take care of Kaiser steel mill employees and their families, the Southern Permanente hospital was in operation today at the Kaiser iron and steel plant near Fontana.

The new hospital is one of the most modern to be found in this area, incorporating all the newest and latest advances in hospital equipment and technique.

The hospital itself is the remodeled original administration building formerly used by the Kaiser Company, Inc., plus a new wing added to accommodate four-bed wards and surgical units for in-patients. The entire hospital has been modernized with a floor plan designed to permit the easiest accessibility to the rooms of all patients from a central work area, thus speeding the service to each patient.

There are four surgical units, similarly designed, each having accessibility to a central sterilizing work room. The hospital has the most modern types of equipment in design, such as a new-style lighting system for the operating rooms, casting brilliant light without shadows. Other provisions have been made for emergency lighting in the event the regular lighting system should fail. One of the outstanding features of this hospital is the elaborate communications system which allows each patient to talk directly to the nurse at her desk, and the nurse to reply to the patient. This saves many steps for the nurses, who by the old system had to first come to the patient's room to answer requests. The hospital itself was built and equipped by the Kaiser Company, but is operated by Dr. Sydney Garfield under a plan similar to the shipyard hospitals in Oakland and Vancouver, which Henry J. Kaiser built at these projects. . . .

Employees and their families may obtain services for a very nominal weekly charge under the hospital service plan of the Southern Permanente hospital. At the present time this service is extended only to the employees of Kaiser Company, Inc., and members of their immediate family. However, in the event there are additional facilities in the hospital, nonemployees of the Company may obtain treatment at regular hospital charges similar to those of neighboring hospitals.—Pomona *Progress-Bulletin*, September 13.

Kaiser to Build East Bay Hospital

Washington, Sept. 15 (AP).—Henry J. Kaiser, West Coast industrialist, said today a new $1,200,000 hospital addition would be built in Oakland, California, with Federal Works Agency funds, for the prepaid care of shipyard workers' families and the public.

Health service will be rendered as in other Kaiser hospitals and clinics, on the basis of a small regular payment by Kaiser workers.

Kaiser said, in an interview, that his industries already had seven hospitals for Kaiser workers on the Pacific Coast who regularly contribute seven cents a day to the hospital funds on a voluntary basis, but that facilities are limited for the care of families.

"I have been arguing that all industry should do this," Kaiser said. "Maybe it should be made compulsory.

"I believe that we have got to take care of both the worker and his family to get production. If a man's family is sick, he isn't productive because he's worried and he's got to take time off."—San Francisco *Call-Bulletin*, September 15.

Pleasanton Navy Hospital to Open

The Navy announced today that a new, large naval hospital would be commissioned tomorrow at Pleasanton, Alameda County.

The first group of buildings will contain about 1,000 beds, but the Navy said, "It is expected that the hospital will be greatly expanded as the war progresses."

Captain Robert P. Parsons of the Navy Medical Corps will be commanding officer of the hospital. He recently returned from the Pacific combat areas, where he assisted in establishment of a hospital.—San Francisco *Call-Bulletin*, September 30.

State Medical Society of Wisconsin Holds Meeting with Hospital Groups

(COPY)

THE STATE MEDICAL SOCIETY OF
WISCONSIN

Madison, Wisconsin,
August 27, 1943.

To the Secretaries of all State Medical Societies.

Dear Friends:

This year, for the first time, this Society is holding a special section program for chiefs of staff, superintendents of hospitals, members of hospital boards, and others interested in the conduct and administration of these institutions in our state.

An effort has been made to arrange a program that would be of joint interest to physicians and hospitals. A copy of the program is enclosed.

The Chairman of our Committee on Hospital Relations has asked that I obtain from you information concerning similar meetings held in your state. Will you please drop me a note advising me if you have held a meeting similar in character and, if so, how it was received and the degree of success of the meeting.

I will sincerely appreciate your doing this.

Cordially yours,
(Signed) C. H. CROWNHART,
Secretary.

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(COPY)

THE STATE MEDICAL SOCIETY OF
WISCONSIN

Madison, Wisconsin,
August 16, 1943.

Chiefs of Staff, Hospital Superintendents, Hospital Board Members, and Others:

Dear Friends:

The Committee on Hospital Relations of the Society has arranged for a special meeting devoted to the subject of "Hospital Relations" as part of the annual meeting program on September 15. Outstanding authorities have been secured to present a program of timely interest to chiefs of staff, hospital superintendents, hospital board members, and others. This program will be presented on Wednesday morning, September 15, in the Milwaukee Auditorium. This meeting will be held at the same time that the one hundred second anniversary meeting of the State Medical Society is held in the Milwaukee Auditorium.

As secretary of the Society it is my privilege to extend to you a most cordial invitation to attend this meeting and to see the many scientific and technical exhibits that will be on display at the Auditorium.

In order that arrangements may be made to accommodate you at the noon luncheon scheduled at the Hotel Schroeder, I would appreciate your returning to me your reservation together with your remittance.

It will be a pleasure to have you attend, as guests of the Society, the morning sectional program.

Cordially and sincerely,
(Signed) C. H. CROWNHART,
Secretary.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Venereal Rate in State Rises

Sacramento, Oct. 4.—Cases of syphilis reported in both civilian and military reports showed an increase of 43 per cent in the first six months of 1943 over the similar period of 1942, the State Public Health Department announced today.

A similar increase in gonorrhea cases was also reported. "It would appear that war conditions are responsible for these increases," the Department declared.

A good part of the increase in syphilis infections was accounted for by cases involving negroes, the Department reported. Negro cases increased 200 per cent in the six-month period over the previous similar period.

The Department also noted the California rate of increase was substantially above an increase reported nationally of 21 per cent.

The Department said separate tabulations of statistics for civilian and military populations are not available and it was impossible to determine the effect of racial groups that have recently migrated into California on civilian rate. —San Francisco *News,* October 4.

Health Education Program

By the San Francisco Heart Committee

A Feature of the Fourteenth Annual Postgraduate Symposium: Public Invited

This program for lay citizens is sponsored by the Second District of the California Congress of Parents and Teachers. To be held at the Mount Zion Nurses' Home Auditorium, 2345 Sutter Street, at 10 a. m., November 5, 1943. An invitation is extended to all who are interested in the prevention of heart disease.

THE MOBILIZATION OF COMMUNITY RESOURCES FOR THE PREVENTION OF HEART DISEASE

S. P. Lucia, M. D., Presiding

Chairman of the Department of Preventive Medicine, University of California. Chairman of the Committee on Health Education

The Federal Program for the Prevention of Heart Disease.—Edith P. Sappington, M. D., District Medical Director, United States Children's Bureau.

State Facilities for the Prevention of Heart Disease and the Care of the Cardiac Invalid—Wilton L. Halverson, M.D., Director of the California State Department of Public Health.

The Position of the Pediatrician in the Program of Preventable Heart Disease—William Palmer Lucas, M. D., Clinical Professor of Pediatrics, University of California Medical School.

The Need for Adequate Convalescent Care for Rheumatic Children.—Miss Ethel Cohen, Regional Medical Social Consultant for the United States Children's Bureau.

The Rôle of the Public Health Nurse in the Program for the Prevention of Heart Disease—Miss Rena Haig, Chief of Public Health Nurses, State of California.

* * *

The prevention of heart disease is a public-health problem. It is of vital concern to the entire community.

To achieve this end the Heart Committee carries on an intensive program of education.

The Heart Committee is a division of the San Francisco Tuberculosis Association.

The Christmas Seals you will buy this year will help support the campaign against heart disease.

Parent-Teacher Association Health Proposal: Preventive Medicine in Preschool Age Group

There has been a tremendous influx of children into this community. Many of these children have had no medical supervision whatever. On September 8, representatives of the Parent-Teacher Association met with a committee of representatives of the Health Council of the Community Chest, San Francisco Department of Public Health, San Francisco County Medical Society, and American Academy of Pediatrics to discuss a program for launching a campaign of preventive medicine in the preschool age group. It was decided at this conference that such campaign should be inaugurated and that the children in this group should be protected against diphtheria, smallpox, pertussis, and tetanus, and that tuberculin tests should be done routinely and Schick tests at the appropriate time after diphtheria prophylaxis is administered.

It was felt by this committee that, so far as possible, all work should be referred to the private practitioner unless the parties involved were unable to pay a reasonable fee. In such cases, these children are to be referred to health centers, clinics, and to the Department of Public Health for their coöperation. It was also advocated that the profession, as well as the above agencies, prepare a comprehensive prophylaxis certificate on which are indicated the various procedures to be carried out, the dosage, the date of administration, and the results; this certificate to be kept safely for future reference by the parents.

The Parent-Teacher's magazine is going to publicize this program, and information slips will be sent to the parents of children of preschool age.

It was suggested that those practitioners called upon for this treatment who are not familiar with the administration of the above prophylactic procedures recommended, inquire of the other members of the profession who have had such experience in order that they may carry out this complete program. The coöperation of the profession in this worthy cause will be greatly appreciated by the committee.—*Bulletin of the San Francisco County Medical Society.*

COMMITTEE ON MEDICAL ECONOMICS

Another Dividend by California State Compensation Insurance Fund, but Not to Physicians

(COPY)

San Francisco, October 1, 1943.

To the Editor:

"Registering a new high mark in unbroken dividend participation over a period of twenty-nine years, the State Compensation Insurance Fund is currently distributing more than $4,250,000 to California employers." This announcement has been made by Paul Scharrenberg, Director of Industrial Relations, and chairman of the Industrial Accident Commission, the Fund's Board of Directors. Fund reports reveal that a favorable accident experience and low operating costs, coupled with the largest annual premium income in its history, have made this showing possible.

Since starting business in 1914, the State Compensation Insurance Fund has distributed $97,000,000 for benefits to injured employees and their dependents, in accordance with the provisions of workmen's compensation laws. A surplus and reserves amounting to $23,500,000 remain on hand. Most of this surplus and the reserves for future payment of incurred claims for injuries are invested in Municipal, State, and Federal Government Bonds. Present total bond holdings of $21,990,000 include $9,866,000 in United States Government Bonds, of which $2,450,000 were acquired during the Third War Loan Drive.

(Signed) STATE COMPENSATION INSURANCE FUND.

War Worker's Lunch Box Far From Adequate.—A survey in Sales Management reveals the mysterious contents of the average war worker's lunch box. Nutrition experts and dietitians would hardly endorse these meals on which millions of workers depend for health and energy. Ninety-nine and nine-tenths per cent of worker's lunch boxes contain sandwiches. Eighty per cent of the sandwiches are made with meat. Desserts, mostly cakes and pies, are found in 65.2 per cent of the boxes. Beverages figure with 34 per cent, coffee predominating. The percentage of vegetables is only 20.4, and salads are not even listed.

Health is one of the two prime requisites for a strong national defense. The other is morale.—Col. William J. Donovan.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (20)

Alameda County (2)

Puttler, S. D., *Oakland*
Terry, Lawrence, *Alameda*

Butte-Glenn County (1)

Whiting, Frank M., *Oroville*

Humboldt County (1)

James, Herbert C., *Ferndale*

Los Angeles County (4)

Barlow, Nathan J., *Bell*
King, Jack W., *Los Angeles*
Scofield, Jr., Dean Stanley, *Los Angeles*
Schiffler. Robert J., *Los Angeles*

Mendocino-Lake County (2)

Barcklow, George T., *Willits*
Havstad, Gordon, *Fort Bragg*

San Bernardino County (1)

Clarke, George W., *San Bernardino*

San Diego County (6)

Brodie, Earl I., *San Diego*
Guerrero, William F., *San Diego*
Ickstadt, Albert Sr., *Coronado*
Kennedy, C. R., *San Diego*
Lambert, Thomas H., *San Diego*
Taylor, Merrel H., *San Diego*

San Mateo County (2)

Myers, Philip R., *San Mateo*
Zillmer, A. L. W., *Burlingame*

Yuba-Sutter-Colusa County (1)

Frantz, John Russell, *Oakland*

Transfers (3)

Abbott, F. E., from Los Angeles County to San Diego County.
Miller, Edward A., from San Diego County to Orange County.
Saylin, Joseph, from Los Angeles County to Orange County.

Retired Members (1)

Bartle, Ira B., *San Luis Obispo.*

In Memoriam

Chapman, William H. Died at Loma Linda, August 19, 1943, age 66. Graduate of the University of Nebraska College of Medicine, Omaha, 1902. Licensed in California in 1910. Doctor Chapman was a member of the Riverside County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✠

Gregory, Frank Starr. Died at San Mateo, August 21, 1943, age 68. Graduate of Cooper Medical College, San Francisco, 1900. Licensed in California in 1900. Doctor Gregory was a member of the San Mateo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✠

Lowe, Wilfred Francis. Died at Sacramento, September 11, 1943, age 40. Graduate of Rush Medical College, Illinois, 1930. Licensed in California in 1930. Doctor Lowe was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

✠

McCarthy, Harry Lloyd. Died at Los Angeles, July 25, 1943, age 65. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1910. Licensed in California in 1920. Doctor McCarthy was a retired member of the Los Angeles County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✠

Wolf, George Lawrence. Died at San Francisco, August 21, 1943, age 62. Graduate of the College of Physicians and Surgeons of San Francisco, 1917. Licensed in California in 1917. Doctor Wolf was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. CHARLES C. LANDIS........President
MRS. ROGER McKENZIE........Chairman of Publicity

A MESSAGE FROM THE PRESIDENT

Dear Auxiliary Members:

At no time in the history of our organization have there been so many calls for the attention, time, and interest of our Auxiliary members as at the present. We must grant that many of the calls are urgent and worthy of our best in coöperation and service. Yet, because we are human, and it is impossible to answer all the calls upon our time, it behooves every doctor's wife to stop and weigh the relative value of the services that she may render to our country during this crisis.

Is there any greater service within our power than to help in maintaining the high standards of American medicine while our doctors are doing their utmost in caring for the armed forces and the civilians? There are forces at work even now that would make the practice of medicine in the postwar days a very different matter than it ever has been. Shall we, as doctors' wives and Auxiliary members, overlook the opportunities there are for service in directing the minds of the lay public to an appreciation of the results of these measures?

Our country needs strong men and women and healthy children in this crisis. Shall we allow, by our absorption in more trivial matters, the leadership in health education to pass to the cultists and faddists?

The amount that each one may do, personally, may seem small, but united as a group in the Auxiliary, our influence will be felt and a great deal can be accomplished. The State Board, in session in Oakland during this past month, approved the plans submitted by the Committee Chairmen to guide in the work of the Auxiliary this year. These have been mailed to the county presidents. Choose from the suggested plans the ones that are best suited to your community needs and the talent of your members.

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† For roster of officers of component county medical societies, see page 4 in front advertising section.

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Roger McKenzie, 138 Twenty-fifth Avenue, San Francisco. For roster of state and county officers, see page 6, in front advertising section.

Let us extend our hospitality in every possible way to the wives of the doctors in the armed forces, helping them to contact the Auxiliary wherever they may be located.

As a special project this year, we urge that each Auxiliary lay plans for placing *Hygeia* in all high school and college libraries, in the reading rooms of the Army camps and the U. S. O. I am sure that there is no place where the authentic information contained in this magazine will be more appreciated.

Each Auxiliary member should be informed regarding Senate Bill No. 1161, and be able to explain it to the lay public. Copies may be secured by writing to the National Physicians' Committee at 55 East Washington Street, Chicago. It is recommended that we contact our Senators and urge their active opposition to this bill.

April has been designated as "Cancer Control Month" by act of Congress. As we plan our programs, let us keep this in mind and give it the emphasis it deserves.

There are many ways by which money can be raised for the Medical Benevolence Fund. This is more needed than ever. Let us do all we can to support this worthy program.

As soon as the new War Participation Committee completes its plans, copies will be sent to each Auxiliary. It is hoped that under this committee our war activities may be coördinated so that our war work as a group may be more effective.

There are many other activities that our Auxiliaries are already maintaining. Let us do our part on the home front so that when the men return they may find that the freedoms for which they have fought have not been destroyed.

Wishing you each a most successful year,

Mrs. C. C. Landis, *President.*

* * *

MEETING OF THE BOARD OF DIRECTORS

The fall meeting of the Board of Directors of the Woman's Auxiliary to the California Medical Association was held at the Claremont Hotel in Berkeley, California, on Wednesday, September 8. There were sixteen members present and fourteen county presidents. Mrs. C. C. Landis, president, was unable to be present due to illness, and her absence was greatly regretted. Mrs. Franklin Farman, first vice-president, ably conducted the meeting.

Reports of various officers and committee chairmen and outlines of the year's work occupied the membership. Among plans submitted for the year were work on the Wagner-Murray-Dingle Bill, aid in recruiting members for the U. S. Nurse Cadet Corps, continued support of the Medical Benevolence Fund, and the work of a new committee on war participation.

The Board was fortunate in having the National president, Mrs. Eben Carey, address them at this meeting. She outlined successful activities in various State Auxiliaries, such as the Doctors' Aid Corps in Georgia and the Supplementary Speakers' Bureau in Wisconsin. Mrs. Carey explained the main project for the year as given by the Council of the American Medical Association, namely, aid in procurement of members for the United States Nurses' Cadet Corps. High school graduates from 17 to 35 years are eligible. They must pass a rigid physical examination and after being accepted may choose the training school they prefer. For the first nine months they receive $15 per month, plus room, board, uniforms, and laundry. For the next ten months, as Junior Cadets they receive $20 per month plus the above extras, while the last ten months of training they are Senior Cadets and receive $30 per month with maintenance. Aid in recruiting may be given through newspapers, Speakers' Bureau, Parent-Teacher organizations, clubs, labor groups, and booths in department stores. Girls already in training may transfer to the Corps.

At noon the meeting adjourned for luncheon, where Mrs. Carey and Dr. George H. Kress were guests of honor.

At the afternoon session the regular business was completed. Later a tea, honoring Mrs. Carey, was given at the home of Mrs. Julian Lunsford by the Alameda County Auxiliary. This gracious gesture was deeply appreciated and enjoyed.

Mrs. Lawrence Gundrum,
Recording Secretary.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (August, 1943)		49,010
Rural Health Program		5,000
War Housing Projects (approximate)		29,559
Marin	5,844	
Los Angeles	7,024	
San Diego	......	
Vallejo	15,035	
San Francisco	1,656	
Total		83,569

Through the instrumentality of the Federal Public Housing Authority, in coöperation with California Physicians' Service, the continuance of medical services for tenants in housing projects has been assured. This is the result of conferences held by California Physicians' Service representatives and the Housing Authority in Washington.

The great and vital need for this service in housing projects was evident to all concerned, and the implications of its discontinuance could have been of major consequence. This was evident to the Coördinating Committee of Procurement and Assignment Service, to the State Department of Public Health, the United States Public Health Service, and the Social Security Board. Through the combined efforts of all these agencies in pointing out the need to Washington, everything that could be done within the legal set-up of the Federal Public Housing Authority has been effected.

The plan provides for prepayment on the part of the Housing Authority in areas certified as to the need by Procurement and Assignment Service to continue with the staff of physicians and nurses that California Physicians' Service has built up during the past nine months. The necessity for smooth continuance of the service is quite evident because of the increasing shortage of doctors, and due to the recognition of the fact that it would be almost impossible to develop a new staff at any known future date.

It is gratifying to have the reaction of the tenants concerned, and of the Housing Authorities concerned, to the effect that California Physicians' Service has rendered a valuable and necessary service, which was evidenced by the vocal expression on their part in the form of petitions, etc., to Washington, pointing out the urgent need for the continuation of this type of program.

* * *

As a result of this action, medical care programs will continue in Marin, Los Angeles, Vallejo, San Francisco, the Fairmont Trailer Camp in Contra Costa County, and the program will go into Alameda as a new plan. These plans will be operating under temporary sixty-day agreements, during which time some permanent plans can be developed.

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† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 5, in left-hand column.

In contacting the local Housing Authorities, most of them evinced an interest in continuing with the prepaid feature that characterized California Physicians' Service's original plan. Being offered to the tenants is a contract with the same benefits included, directed at protecting the health of the community. The rates were left the same—that is, $2.50 for a single person, $4 for a married couple, and $5 for a family of three or more. Excluded from the contract were obstetrical care, which had taken such a large proportion of the income, tonsillectomies, herniotomies, and correction of congenital defects. The figures of the past nine months' experience indicate that with these items deleted, and with the assurance of at least 90 per cent participation of all tenants, the program is financially sound.

In the meantime, service is continuing in all of the areas, which is extremely vital at this time because of the approach of the winter months, when the incidence of illness is expected to increase considerably.

The attitude and understanding of the physicians involved during the period of uncertainty, and in the face of continuing service for practically no fee, is to be commended. It is also of interest to note that in many of the projects the families continued on with their prepaid dues during the entire period. There was little loss of membership during the last couple of months.

On Events in Federal Housing Areas in California

The meeting of California Physicians' Service representatives and others, with Federal Housing Authority officials in Washington, D. C., was preceded by conferences in San Francisco, concerning which a statement of July 30, 1943, by Dr. A. E. Larsen, Secretary of California Physicians' Service, gives further information:

CALIFORNIA PHYSICIANS' SERVICE

July 30, 1943.

Enclosed find copy of a letter which was recently sent to all housing authorities with which California Physicians' Service has entered into contracts to render service in the Federal Housing Projects.

You are undoubtedly aware that the California Physicians' Service program is inadequately financed, to the point where we cannot continue to ask local physicians to accept the insufficient fees for services that we are able to pay. This notice follows out of a sequence of meetings with the Coördinating Committee of the Procurement and Assignment Service of the War Manpower Commission, which adopted the following resolution:

"It is the considered opinion of this Committee that the present method of furnishing medical care to residents of housing areas, through California Physicians' Service, is the most desirable method known to the Committee under present circumstances, and we recommend that the Federal Public Housing Authority be urged to take all steps necessary, within its authority, to obtain the necessary funds to insure that this program shall be continued."

The second meeting was with all of the housing authorities concerned, which adopted a resolution which we quote in part:

"1. It is essential that medical care be made available to residents of War Housing Projects.

"2. It is agreed that California Physicians' Service is the only medium through which such service can be made available in these critical war areas."

A third meeting was held with all of the governmental agencies concerned with war production, together with the United States Public Health Service, State Department of Public Health, and the California Medical Association. A resolution was adopted by this group as follows:

"Resolved, that the Federal Public Housing Authority be requested to recognize the great need for medical care in housing projects in communities that cannot be provided for by any other means, and that the FHPA be requested to authorize local housing authorities to enter into such contracts with California Physicians' Service as may be necessary and desirable for insuring the continuation and extension of the California Physicians' Service program."

We hope to get speedy action on this combined public sentiment. It will be necessary that this matter be taken to Washington for final decision. We shall keep you informed from time to time of subsequent developments.

In the meantime, we should like to urge upon participating physicians the necessity of continuing to discharge our contractual responsibility. It is to be remembered that the financial position of the housing projects in no way affects the regular California Physicians' Service program for commercial groups.

Very sincerely,

A. E. LARSEN,
Executive Medical Director.

* * *

CALIFORNIA PHYSICIANS' SERVICE

San Francisco, July 29, 1943.

Mr. Albert J. Evers, Executive Director
Housing Authority of the
City and County of San Francisco
525 Market Street
San Francisco, California

Dear Mr. Evers:

In accordance with the terms of the Medical Service Agreement entered into between California Physicians' Service and the Housing Authority of the City and County of San Francisco, dated April 19, 1943, we hereby notify you that our agreement to render service thereunder will terminate as of September 30, 1943.

We sincerely regret the necessity for the termination of these arrangements, but our experience to date indicates the obvious impossibility of financing the costs of these services out of present income. During the period from September, 1942, to May, 1943, inclusive, California Physicians' Service professional members have rendered services of which the total cost in all projects throughout the state amounts to $365,000. Our total income from tenants of housing projects during the same period was $241,000.

We believe that every effort has been made by the Housing Authority and by California Physicians' Service to make the present program successful, and we wish to express our appreciation for the assistance and coöperation that you have given to us in attempting to make this necessary service available to the tenants of housing projects.

Very sincerely,

A. E. LARSEN.
Executive Medical Director.

C. I. O. Acts to Save Health Project for Harbor Area

Los Angeles, Sept. 10.—Los Angeles C. I. O. Council's Executive Board is urging an immediate conference of the Federal Housing Authority, California Physicians' Service, tenants of harbor housing projects and organized labor in an effort to save the lowcost medical service at the Banning and Wilmington housing projects.

Inadequate financial returns and opposition by county medical societies are the main reasons why California Physicians' Service intends to terminate its services on September 30 unless it gets a new contract calling for subsidies by the Federal Housing Authority and greater limitations of the plan.

The California Physicians' Service is a voluntary prepayment medical plan which operates under the auspices of the California State Medical Society in conjunction with the Blue Cross Hospitalization plan.

The housing authority furnishes quarters and equipment. The doctors make available specialist care and hospitalization outside of the projects at the relatively low cost of $2.50 for an individual, $4 for a man and wife, and $5 for a family unit, to be collected with the tenants' rent if he chooses to avail himself of the service.

What a discontinuation of the health program would mean to California is indicated by the C. I. O. statement that tens of thousands of workers are about to be deprived of even a minimum of medical care "threatening thereby not only the immediate community of the housing projects, but the West Coast as a whole with epidemics and general health deterioration."

The C. I. O. Executive Board recommended to all agencies concerned that the low-cost medical program be continued under any circumstances. At the same time the C. I. O. appealed to the U. S. Public Health Service for immediate allotting of physicians' and nurses' services in the event that contract negotiations with the California Physicians' Service are fruitless.—San Francisco *People's World*, September 11.

Steps Taken to Continue California Physicians' Service In Vallejo

A most serious crisis threatens Chabot Terrace if the California Physicians' Service withdraws its activities on September 30 as planned, according to Ray Martin, 412 Siskiyou Avenue, Chabot Terrace, who was appointed chairman of the "Save the California Physicians' Service" Committee at a business meeting of the CCCC's Monday evening.

Mr. Martin pointed out the obvious hazard to the community in case of epidemics in the face of the present shortage of nurses and doctors. He pointed out the financial record of the Chabot Medical Center as evidence that it cannot operate without a better contract. It must break even at least. In May the total income was $13,486.15 and the total expenditures, $19,555.76, leaving a deficit of $6,069.61.

A plan was evolved Friday at a meeting at Harbor Gate Project in Richmond which Mr. Martin attended, calling for every housing project in the bay area to petition Washington to make it possible for the California Physicians' Service to be retained.

Thursday and Friday of this week, August 26 and 27, petitions will be circulated in Chabot Terrace. Everyone interested in the welfare of his family is asked to sign the petition and to help in its circulation. Those willing to assist are asked to see Mr. Martin or Project Services Office.—Vallejo *News-Chronicle*, August 25.

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(Continued from page 214)

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(Continued from page 224)

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MEDICAL EPONYM

Stokes's Collar

William Stokes (1804-1878) first described this phenomenon in the *Dublin Journal of Medical and Chemical Sciences* (5:400-440, 1834), in an article entitled "Researches on the Diagnosis and Pathology and Aneurysm." He discusses a case of aneurysm of the aorta as follows:

"I was at once struck with the peculiar appearance of the neck. This was generally enlarged (giving the idea of the patient's wearing a collar or tippet), the jugular veins were turgid and tortuous."

He also mentions the phenomenon in the first part of *A Treatise of the Diagnosis and Treatment of Diseases of the Chest* (Dublin, 1837, page 231) and again in *The Diseases of the Heart and the Aorta* (Dublin, 1854, page 573), as follows:

"As an indication of intrathoracic tumor, an extremely varicose state of the superficial veins of the neck and thorax is probably less frequent in aneurismal than in cancerous diseases. The pressure may be exercised on the venae innominatae or the superior cava. . . . In other cases we find that in place of the large tortuous veins ramifying on the surface, there is a puffy elastic swelling of the entire neck. To this may be given the name of tippet-like swelling of the neck."—R. W. B., in *New England Journal of Medicine.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Meetings will be held in San Francisco. Date of the seventy-third annual session, to be held in 1944, to be announced later.

* * *

American Medical Association. Place and date of 1944 annual session to be announced later.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and the Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 11:45 a. m., under the title, "Your Doctor and You."

KFAC will present these broadcasts on the following Saturdays: October 2, 9, 16, 23, and 30.

The Saturday broadcasts of KECA are given at 11:15 a. m., under the title, "The Road of Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association, in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy, are on the air each Saturday at 2 p. m., Pacific War Time.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Special Issues:* Congratulations to Benno Schwabe & Co., Basle, for the special chemotherapy number (19/20) *Schweizerische Medizinische Wochenschrift,* 1943, dedicated to the International Committee of the Red Cross. Pages 549 to 685 deal mostly with sulfonamide derivatives in various clinical conditions, with general discussion by R. Stachelin, H. Staub, M. Hartmann, and R. Meier on basic principles, and bibliography of 958 articles by O. Merkelbach. Interesting how little United Nations' scientific or medical publications have reached Switzerland since 1942. But even the University of Basle offers special courses in tropical medicine. To be noted are F. Verzar's *Theorie der Muskelkontraktion* and A. L. Vischer's *Das Alter als Schicksal und Erfüllung;* also the new *Helvetica Physiologica et Pharmacologica Acta,* quarterly at Fr. 31.50, if you can get it! The June, 1943 issue of the *Bulletin of the American College of Surgeons* (28:90-239) is all war, from care of the injured to a selected bibliography. The July issue of CALIFORNIA AND WESTERN MEDICINE has a tuberculosis supplement (59:25-71, 1943) which deserves wide circulation, reprinting, and a lot more rayrah; most of the notes warrant extension and republishing.

2. *And More Books:* C. C. Thomas (now in Frank Lloyd Wright's Springfield (Illinois) house, announces I. H. Page's *Hypertension*—a manual for patients; and C. C. Higgins' *Renal Lithiasis. New and Nonofficial Remedies* (A. M. A., Chicago, 1943 issue), continues to show improvement in organization and material. Williams & Wilkins (Baltimore) issue B. Ratner's *Allergy, Anaphylaxis, Immunotherapy.* Macmillan (New York, 11) offer W. K. Livingston's *Pain Mechanisms: A Physiological Interpretation of Causalgia.* P. B. Hoeber has another W. C. Alvarez on *Nervousness, Indigestion and Pain,* and has ready a big *Clinical Tropical Medicine,* edited by A. T. Bercovitz. Finally, there appear both volumes of the important *Pharmacology of the Opium Alkaloids,* by H. Krueger, N. B. Eddy, and M. Sumwalt (Suppl. 165, Pub. Health Rep., Washington) with a whopping bibliography of over 10,000 items! American Council of Public Affairs, Washington, issues S. Wilson's *Food and Drug Regulation.* Symposium of Association for Research in Nervous and Mental Diseases on *Rôle of Nutritional Deficiency in Nervous and Mental Disease* is published by Williams & Wilkins. And we have just received the same outfit's *Antigonadotropic Factor with Consideration of the Antihormone Problem,* by B. Zondek and F. Sulman. Also note *Cytology and Cell Physiology,* edited by G. Bourne, and including sections by J. F. Danielli and H. Blaschko, offered by Oxford Press at 20s. C. C. Thomas published *Medical Progress Annuals,* covering series of articles appearing in the *New England Journal of Medicine.*

3. *Interesting:* J. Davidson finds body-louse eggs develop 25 per cent per day at body heat (*Med. J. Austral.,* 1:533, June 12, 1943). R. H. Williams and G. W. Bissell confirm E. B. Astwood's finding (J. A. M. A., 122:78, 1943) that thiouracil successfully controls thyrotoxicosis in doses of 0.2 gram per four hours, giving blood concentration of 3 milligrams per 100 cubic centimeters, and 300 milligrams per day in urine (*Science,* 98:156, August 13, 1943). F. R.

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† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

Winton & Co. report renal damage after crush injury to limbs (*Quart. J. Exp. Physiol.*, 32:89, 1943; M. C. Sanz (Bern), in studies on brain metabolism, finds no acetylcholine production in absence of glucose and increase in metabolism with HCN (*Pfluger's Arch. ges. Physiol.*, 246:597, 1943). G. Domini and H. Rein (*ibid.*, p. 608) confirm our old report that lactate ions dilate peripheral vessels independently of pH (*Am. J. Physiol.*, 80:107, 1926). H. Kwiatowski (*J. Physiol.*, 102:32, 1943) finds much histamine in distal parts of sensory nerves, none in central nervous system or motor nerves, proposes histaminergic nerves. B. C. Bose and B. Mukerji discuss physiologically active fractions of Indian hemp (*Nature*, 152:109, July 24, 1943). In July *Physiological Reviews* are articles by E. F. Hirsch and S. Weinhouse on lipids in atherosclerosis; L. Pauling & Co. on antigens, antibodies, and precipitation reaction; and F. A. Hellebrandt on vertical stance of man.

4. *Ave. Helvetica Physiologica et Pharmakologica Acta*, O. A. M. Wyss, Geneva, Editor. First issue contains articles by S. Burgi on tegmental reaction; A. Fleisch on Vitamin A; W. R. Hess on subcortical centers; W. Bloch on relation of hypothalamus to resp. metab.; W. Schuler on relation between age and metabolism; and proceedings, January 30 meeting of the Swiss Society for Physiology and Pharmacology.

Ninetieth Birthday of San Francisco County Medical Society.—The San Francisco County Medical Society cordially invites members of the California Medical Association to attend the meeting in celebration of its ninetieth birthday on Sunday, November 7. Clinics in general medicine and general surgery will be conducted in the morning at Lane Hall, Stanford University Medical School, and Toland Hall, University of California Medical School.

"The Future of Medicine" will be the subject of a symposium to be held in the afternoon at the home of the County Medical Society. Dr. Morris Fishbein of Chicago, Dr. Walter H. Brown, chairman of the Department of Hygiene, University of California, and other speakers to be announced later, will participate.

Governor Warren Appoints Two Members to State Health Board.—Governor Warren on September 28 appointed Dr. Sanford Moose of San Francisco and Dr. Samuel J. McClendon of San Diego to the State Board of Health.

They replace, respectively, Dr. V. A. Rossiter, Santa Ana, deceased, and Dr. F. W. Pottenger, Los Angeles, resigned.

Birth Rate Jumps in War.—In its first full year of World War II—1942—the nation's birth rate was the highest in sixteen years and the death rate the lowest on record.

The Census Bureau so reported on September 25. Births totaled 2,808,996, an increase of 11.8 per cent over the 1941 figure, and deaths, not counting war casualties abroad, numbered 1,385,187, a decline of 0.9 per cent from the preceding year.

United States Health Picture "Favorable," Says Office of War Information.—The Office of War Information today painted a "generally favorable" picture of United States civilian health despite a shortage of doctors which will continue to increase "indefinitely," barring revision of military requirements.

Summarizing the results of its second survey of the nation's medical defenses, OWI found 108,000 physicians—out of the total prewar registry of 180,000—still available to care for the remaining civilian population of 120,800,000 persons.

If this total were perfectly distributed, OWI said, it would mean one doctor, in general practice, for every 1,557 persons—very close to the desirable ratio of one to 1,500. Perfect distribution does not exist, however, and is not attainable without compulsory shifts of doctors to critical localities.

"Undoubtedly, the most acute health problem affecting the nation as a whole arises out of the increasing shortage of doctors and dentists," the report stated. "The shortage . . . will continue to increase indefinitely unless the requirements of the armed forces are revised."

The Office of War Information said, however, that the armed forces so far have commissioned only a little more than 80 per cent of their needs and also are taking 80 per cent of all new medical graduates. Only 1,500 of the 7,000 new medical graduates each year will be available to replace the 2,500 to 3,000 doctors who die annually.

Despite the shortage of physicians, OWI found the increased rate of sickness among war workers no greater "than might be expected under the strain of war-time living and working conditions."

A 68 per cent increase during the first quarter of 1943 was reported in worker absences of eight days or longer because of respiratory diseases, particularly influenza and grippe.

State Health Talks at C. I. O. Parley.—Dr. Wilton L. Halverson, Director of the California State Department of Public Health, was one of the speakers at an all-day health conference of the Los Angeles C. I. O. Council on Sunday, September 19.

"Health Joins the C. I. O." will be a working conference at which C. I. O. union delegates will have a chance to set up a full-time health division within the C. I. O. Council, and to share in the planning of the program for such a division.

Among the speakers was Dr. Morris Raskin, medical coordinator of the Medical Research Institute of the UAW, and a pioneer in union health planning. Doctor Raskin discussed Industrial Health as it affects the workers, and how unions can help safeguard the health of their fellow workers.

The topic of Medical and Hospital Care was discussed by Dr. Asher Gordon, resident physician at the Vallejo housing project and a member of California Physicians' Service, a prepayment group medical plan.

Dr. Henry Borzook, professor of biochemistry at the California Institute of Technology and his coworker, Miss Nancy Upp, field director of the Los Angeles County and City Committee for Nutrition in Industry discussed how we can keep our workers at the highest level of efficiency through proper feeding methods in the plants.

Dr. Clyde K. Emery discussed the proposed Wagner-Murray-Dingell Social Security Bill and its health and hospitalization aspects.

The conference was open not only to elected delegates, but to the entire membership of the Los Angeles C. I. O. Council. Interested representatives from public and private health agencies received invitations to attend as observers.

Infantile Paralysis in Sonoma County.—Dr. E. D. Barnett, Sonoma County health officer, left on September 1 for Buffalo, New York, to present a report at the American Hospital War Conference.

In a summary of infantile paralysis cases cared for at the Sonoma County Hospital, where he is medical supervisor, Doctor Barnett stated that of 70 patients treated up to August 28, 44 were males and 26 were females; that 52 per cent of those admitted as victims were between the ages of three and twelve years; that 56 per cent had headaches as symptoms, 50 per cent stiff necks, 55 per cent muscle pains, 38 per cent fever, and 19 per cent were suffering from apprehension and displayed extreme restlessness.

His report also showed that 19 per cent had "sore throat," 18 per cent vomited; 84 per cent had back muscles affected, 69 per cent had weaknesses in their hamstrings; 52 per cent were affected in the diaphragm muscle, and 52 per cent in the abdominal area.

Venereal Disease Medicine Needs Doctor's Approval.—Medicines for the treatment of venereal diseases can be sold in California only upon the prescription of a duly licensed physician.

Dr. Wilson L. Halverson, Director of the State Department of Public Health, announced this on September 6, saying the new regulation is provided in a law passed by the last legislature. The restriction also provides that prescriptions containing the sulfonamide drugs cannot be refilled without a doctor's order.

In announcing the new law, Doctor Halverson praised the druggists who, he said, in the majority of cases had complied voluntarily with the provisions of the law before the legislation was passed.

"Only a skilled physician can treat venereal diseases successfully. Self-treatment and inadequate treatment often make syphilis and gonorrhea more difficult to cure," Doctor Halverson said.

He added that local health departments maintain free public clinics where anyone can receive diagnosis and emergency treatment. Continued free treatment is given patients unable to pay a doctor's fee. The State Department of Public Health provides free antisyphilitic drugs to doctors in private practice for the treatment at a reduced rate of patients who cannot pay the full charge.

Two Thousand Five Hundred Use San Francisco Medical Telephone.—Nearly 2,500 persons, mostly newcomers to San Francisco, engaged physicians during the past three months through the San Francisco County Medical Society's "around the clock" telephone service bureau, it was announced recently.

The Society established the telephone bureau as a public service especially for newcomers to the city and for old-time residents whose doctors had departed for the war. The Society's membership was first polled to locate physicians who could take additional patients, and doctors who could take night calls.

Government Fiscal Statistics.—A Washington dispatch of September 25 gives the following summary of Government expenses and receipts for the current fiscal year through September 23, as compared with a year ago:

	This Year	*Last Year*
Expenses	$ 20,621,580,896.54	$15,009,688,011.42
War spending	19,076,051,240.10	13,543,150,516.03
Receipts	8,976,010,581.89	3,599,624,606.89
Net deficit	11,645,570,314.65	11,407,909,054.53
Cash balance	15,422,135,848.46	2,736,665,910.78
Working balance	14,659,438,645.27	1,974,186,793.69
Public debt	158,830,956,110.02	88,246,514,290.55
Gold reserve	22,204,723,013.48	22,750,375,074.42

Doctor Disagrees With Two of Sister Kenny's Practices.—A United Press item states that Dr. Joseph Moldaver of the Columbia University College of Physicians and Surgeons' Department of Neurology expressed disagreement with two of Sister Elizabeth Kenny's theories about poliomyelitis.

In an article in *The Journal of the American Medical Association*, Doctor Moldaver emphasized, however, that his criticisms were concerned in no way with the Kenny treatment methods.

Sister Kenny believes, he said, that infantile paralysis victims suffer "mental alienation" of muscles, meaning that the muscles around the paralyzed area are dissociated from the brain.

This mental alienation of muscles does not exist, Doctor Moldaver said. Studies of forty-nine victims of the disease showed that the muscles lose their power because the anterior horn cells are damaged or destroyed, he said.

Muscle spasm, contraction of muscles, is regarded by Sister Kenny as the most serious and damaging symptom in the disease, Doctor Moldaver said. The danger of paralysis lies mainly in allowing the spasms to continue, she believes.

"Muscle spasm is not the most dangerous symptom," Doctor Moldaver said, "and it does not lead to nerve and muscle degeneration."

Number of Doctors in San Francisco Is Plenty for City's Needs.—San Francisco has plenty of physicians to attend its sick.

This announcement was made on September 23 by Dr. Harold A. Fletcher, State Chairman of the War Manpower Commission's Procurement and Assignment Service.

A survey conducted in San Francisco by the Service disclosed there were now 1,253 physicians actually caring for the sick in San Francisco, indicating, he said, that 474 doctors have entered military service from this city since 1940. Some of the 1,253 physicians, Doctor Fletcher said, are engaged part time in research, laboratory work or other activities not directly connected with the treatment of ill people.

"There is no need to worry about the medical coverage of San Francisco at the present time," Doctor Fletcher said. "There are 816 general physicians, specialists in children's diseases, and general surgeons practicing here. In addition, there are 437 specialists in all the various medical specialty branches.

"The most recent population figures show 691,609 people in the city, which means that the ratio of doctors to population is greater than one to 600, with all the specialties well represented. For a city the size and character of San Francisco, a ratio of one to 1,000 would be considered very reasonable medical coverage, and a ratio of one doctor to 1,100 or 1,200 people would not be considered a dangerous condition."

Although there are enough doctors for quite adequate medical care, Doctor Fletcher said there is an actual shortage of hospital beds, which, however, has not yet had a bad effect on the community's health, but might during the winter months.

Research Group Leader Named.—The Board of Directors of Government Research, Inc., have elected John R. Richards president and will meet on October 5 to name an executive secretary.

Officers serving with Richards are Dr. Elmer Belt, vice-president, and Dean E. Christy, treasurer. Frederick N. Edwards is acting as counsel.

Seventy-five new members have been received in the past month, and the rate of applications received is increasing. The organization announced a membership of more than 5,000 interested citizens is being planned.

The organization has offices in charge of Mrs. Dorothy Dickinson at 411 West Fifth Street.

Dr. Courtney Smith New Area Medical Officer.—Dr. Courtney Smith, formerly assistant commissioner of health in the Territory of Alaska, recently took over his new duties as regional medical officer for the Ninth Civilian Defense Region, succeeding Dr. Fred T. Foard, now assigned to the Eighth Public Health Region in Denver, according to an announcement by George L. Levison, regional OCD director.

Pleasanton Naval Hospital Open.—The U. S. Naval Hospital at Pleasanton, Alameda County, accommodating one thousand patients, was formally commissioned recently by Rear Admiral Daniel Hunt, district medical officer.

Captain Robert P. Parsons, recently returned from duty in the Pacific combat area, will be in charge of the new hospital.

"KAISER WAKES THE DOCTORS": A BOOK REVIEW*

Kaiser Wakes the Doctors. By Paul de Kruif. Cloth. Price, $2. Pp. 158. New York: Harcourt, Brace and Company, Publisher, 1943.

Foreword.—The editorial, "An Author, de Kruif, Finds in California the Solution of Future Medical Practice," states that excerpts from the book "Kaiser Wakes the Doctors," a copy of which has been sent to CALIFORNIA AND WESTERN MEDICINE for review, would appear elsewhere in this issue.

The excerpts referred to are here used as the basis for a review of Author Paul de Kruif's book. This seems to be as good a method as any for bringing to the attention of readers the nature and scope of Author de Kruif's views.

The excerpts, in quotations, in each instance appear in light-face type, followed by the reviewer's comments in italics. No doubt, other answers will also occur to readers. If space were available, additional comment could be made. Book review follows:

Book Review: Excerpts and Comments

"This book had its initial spark in a little story, 'Tomorrow's Health Plan—Today!,' published in the May, 1943 issue of *The Reader's Digest.*"

Comment.—At a luncheon at one of the clubs in San Francisco at which some twenty or more guests were present, Mr. de Kruif told the story of the above article—how it had been rewritten and rejected a dozen or so times before acceptance. The thought flits into the mind that his book may contain some of the ideas he incorporated in his initial drafts. The May, 1943 article referred to was an interesting statement.

* * *

"The banging, clanging, rhythmic flow of men and steel into a Liberty ship, complete from keel to launching within five days, is not the most epochal event at Henry Kaiser's shipyards."

Comment.—Citizens, everywhere, share in the admiration for the splendid organization procedures Mr. Kaiser and associates have brought into being in their shipbuilding and other wartime industries. When de Kruif begins Chapter I of his book with the above sentence, he overlooked the man-hours, covering many days, needed in the building of a ship. Newspapers have told that story.

* * *

"So, under Henry Kaiser's guidance, it is the workers themselves who are building the model of a Mayo Clinic for the common man. Here where there is no money consideration between the sick man and his physician, you see a blueprint for group medical practice for the common man, for the powerful preventive medicine of our doctors for tomorrow."

Comment.—If deducting fifty cents per week from the pay of each worker, to cover sickness insurance supplied by the attending physicians, is not a "money consideration," what is it?

* * *

"What have I [de Kruif] done to fight for the medical underdogs, the medical have-nots? Their numbers are far greater than those who in the great depression were ill-clothed, ill-housed, ill-fed."

Comment.—Social welfare workers would probably take issue with de Kruif on the above, and would be tempted to call attention to the fact that poverty, which causes people to be "ill-clothed, ill-housed, ill-fed," is an important causative factor in many illnesses; and that there are many more poverty-stricken persons than there are of the group of human fellows, to whom the author refers to as "medical underdogs."

* * *

"Like any other form of insurance, these prepaid medical care plans have spread the risk, so that sick people's unbearable financial burden might be shared by those who are well. But here was the catch: these prepaid medical care plans were *medically* not popular: it was the organization of the doctors themselves who opposed them."

Comment.—The large number of "prepaid medical plans" which are in operation throughout the United States, with full coöperation of physicians, is the best answer to the above.

* * *

"About medical care he [Mr. Kaiser] was fanatic."

Comment.—Did Author de Kruif look up the meaning of the word "fanatic"? The Oxford English Dictionary states: "Fanatic . . . affected by mistaken enthusiasm . . . an unreasoning enthusiast."

Did de Kruif wish to give such a meaning to Mr. Kaiser's labors?

* * *

"Then he [Mr. Kaiser] uncovered one of the secret weapons that he was sure would bring us victory in America's coming fight for nation-wide health. 'We won't need Government handouts,' he explained, with fire in his eyes and a slow smile. 'Our medical chief, Doctor Garfield, has proved at Coulee Dam, and is proving now at Richmond shipyards, that if you properly organize and distribute the burden of payment for the best kind of hospital and medical care, the hospitals will quickly amortize themselves; *they'll pay themselves off!*'"

Comment.—With the type of set-up in operation in specialized fields of industrial endeavor, with a particular group of what might be called selected risks, with money cost deducted from pay envelopes without acquisition expenses, etc., and with additional income from state compensation funds to the amount of 40 per cent for industrial injuries, it may be possible for "hospitals to quickly amortize themselves."

Not so, however, when both sexes and all ages are cared for under altogether different conditions. A study of the history of hundreds of hospitals, from one end of the United States to the other, will emphasize this.

* * *

"Even if the manufacturers would go for his plan [Mr. Kaiser's], seeing as how good medical care would lower their man-hours, vastly raise their production—even so, could Kaiser convince the doctors? The physicians whose voices are most powerful in organized medicine are specialists who make good livings on fees, not from the common but from the *un*common man. 'These specialists largely guide the medical rank and file. Will they be interested?' I asked."

Comment.—The statement concerning "physicians whose voices are most powerful in organized medicine" is not in accord with the facts. The biographical files of the American Medical Association in Chicago contain abundant proof to the contrary.

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* For editorial comment, see page 207.

"He [Kaiser] had it clear that, under the individualism of private practice, all was not too secure with the bread and butter of scores of thousands of little doctors."

Comment.—Who and where are these "scores of thousands of little doctors" whose "bread and butter . . . is not too secure"?

If they exist by the "scores of thousands," it should not be difficult for de Kruif and company to point some of them out.

* * *

" 'Remember [Author de Kruif speaking of himself] that your life is justly said to be a series of enthusiasms.' "

Comment.—After perusal of the de Kruif book, one is much tempted to concur in the author's diagnosis of his own condition.

* * *

"The tough part of it would not be convincing the industrialists: they didn't mind stronger manpower. The tough job wasn't convincing the bankers: they would love financing hospitals and health centers if these were a sound investment. And the people—no, 135,000,000 American people would not mind prepaid medical care, for which they all would equitably pay, which would relieve them of their pain, sickness, misery, and needless death."

Comment.—The reason bankers have been reluctant to finance hospitals has been due to their actuarial and other knowledge which proved to them that many hospitals are not "sound investments."

And de Kruif is very much in error when he states "135,000,000 American people would not mind prepaid medical care." The experience of California Physicians' Service with some 7,000,000 inhabitants of that State bears testimony on this point. Healthy people are not yet enamored of prepaid medical care, and without the coöperation of this group, the excessive proportion of poor risks will always endanger the actuarial soundness of voluntary sickness insurance plans.

* * *

"And the people? Alas, they were not organized, they were inarticulate. The voice of the common man could not reach the doctors."

Comment.—What a lack of understanding concerning the lives of physicians!

If there is one group whose members do hear the "voice of the common man," it is the doctors. Let de Kruif read Robert Louis Stevenson's tribute to physicians.

* * *

"He [Kaiser] believed that what he had begun for more than 100,000 shipbuilders could be done, too, for smaller industries, for communities rural as well as industrial."

Comment.—This is a statement of very broad scope not in harmony with past experience. As stated in the editorial comments in the current issue, logical conclusions are dependent on sound premises.

* * *

"Garfield—with a vision of the new death-fighting possibilities of group medical teamwork—had begun his experiments in modern medical care as a lone wolf in the southern California desert. He had graduated from the excellent University of Iowa Medical School and then had migrated to the modern Los Angeles County Hospital, where the lucky poor people of the region get medical science better, on the average, than that of the middle or even the upper economic brackets. Here Garfield, during his years of service as an intern and a surgical resident, had it burned into him *why* the treatment of the poor man, the 'medically indigent,' is so superior."

Comment.—The writer had the privilege of serving on the attending staff of the Los Angeles County Hospital for more than twenty-five years during all of which time he was also a member of its medical executive board. Therefore, he should know somewhat about the institution. Good as the ward and other service rendered by that hospital may be, it is not in accord with facts that in its wards "the lucky poor people of the region get medical science better, on the average, than that of the middle or even the upper economic brackets," who are under the care of the Los Angeles physicians who are in private practice. These same physicians give their services without cost to the County Hospital patients. How absurd it would be for them, since they earn their living in private practice, to give the latter group a lesser quality of service. The author's statement refutes itself.

* * *

"What it boiled down to for the men was that they felt they owned this health plan; they'd all helped pay for it. What it meant for the doctors was that, when there was no money consideration between them and their patients, there was the chance for simple Christianity to come in. Exit dollars—enter God."

Comment.—Rather interesting. The author would seem to imply that physicians in private practice do not carry on their work in accord with the principles of "simple Christianity."

And from whence and how did he receive the message, "Exit dollars—enter God."

* * *

"That day he [Henry Kaiser's son] had taken his noon meal at the best hotel in Richmond, California, close by the Kaiser shipyards. 'There were a lot of shipyard workers eating in that dining room; and you should have seen the right-hand side of the menu card—prices like the Waldorf in New York,' said Edgar. [Mr. Kaiser's son] 'The men were ordering *pheasant.* They were liking it. Believe me, they're not going to forget they once earned money enough to order pheasant,' said Edgar, laughing, and in his laugh there was the ring of high approval. If a manager thinks pheasant is okay for the workmen, he is not likely to let them down on their medical care."

Comment.—Some out of the ordinary premises for a peculiar conclusion.

* * *

"There is no trouble getting modestly paid men to spend the equivalent of half a pack of cigarettes a day when they know that this will guarantee them the best unlimited medical attention."

Comment.—The statement is not in harmony with experience in medical service plans. California Physicians' Service gave unlimited service and found it could not be successfully carried through. The author had access to the California Physicians' Service reports and yet makes the above statement.

* * *

"The family prepaid health plan was advertised and announced at union meetings. It was an unexpected flop. Within three months' time, only some 10 per cent of the workmen's wives and children had signed up for it. What actually happened was what has defeated the bookkeeping of more than one voluntary health insurance plan. The wives and children were not signed up for it, most of them, *until they took sick.* You can see how this threatened to wreck Garfield's set-up."

Comment.—The above presents interesting contrast to the statement quoted from a preceding page.

If persons to be covered do not sign up "until they took sick," it is easy to understand why a prepayment plan will break on financial rocks.

"'The most amazing part of the whole thing,' said Garfield, 'was that when we had the plan started and well along in operation, people stopped dying.

"'That sounds funny, but actually what it meant was that people came to us; the reason they stopped dying was the fact that they came to us with their early symptoms."

Comment.—It is granted that, in a limited number of cases, lives are saved by early treatment. Prepayment plans help to this end, but not to the extent that "people stopped dying."

✓ ✓ ✓

"If we free their hands, if we let them use all their science, our doctors can do more than merely mend bone and brain and muscle. They can build faith and courage in the common man."

Comment.—Physicians have been building "faith and courage in the common man" from the beginning of recorded history and their hands have been "free" always.

✓ ✓ ✓

"Kaiser's keymen, his two sons, Edgar and Henry Jr., included, were driven to the limit of their strength, and then beyond it, yet kept on working. Henry Kaiser himself enjoyed it. To supercharge his natural super energy, the giant [Mr. Kaiser] demanded more and better vitamins. New pills of these powerful chemicals were recommended to him. . . ."

Comment.—What were these wonderful vitamins? And are they prescribed for all the shipyard workers? In connection therewith, refercnce may be made to a newspaper dispatch of a few days ago, in which it was stated that in a new concentrated food packet for shipwrecked soldiers and sailors, a few vitamin pills were placed to fill vacant space in the packages, because, owing to wide press publicity concerning vitamins, the pills helped in the sustaining of morale.

✓ ✓ ✓

"Then he [Doctor Garfield] explained that the whole project would pay itself off reasonably quickly from the money rolling in from the weekly 50-cent pieces voluntarily prepaid by 30,000 workers, plus fees from their industrial compensation insurance."

Comment.—If the above is applied to, say, 100,000 workers in the Kaiser shipyards, the following calculation concerning income may be made: The daily nickels on the basis of fifty cents per week, or two dollars per month, in twelve months, say for 100,000 workers, would mean an income of $2,400,000. Add to that 40 per cent more for the income received through state compensation payments, a sum then in excess of $3,000,000.

When the income is received by the central plant, with acquisition and administrative costs held down to a minimum, in a group of selected risks of sufficient size or mass spread, it is quite easy to understand how "the whole project would pay itself off reasonably quickly."

✓ ✓ ✓

"By the time Kaiser had returned West, Garfield was ready with a smart idea, really a wonderful idea, put into his head by his medical friend, Dr. Ray Kay. 'You and Mrs. Kaiser can make it a Foundation,' Garfield said. 'A Foundation not for profit. Then when our health plan has paid this one off, with all the money coming in we can do great scientific things; we can build *new* hospitals, more hospitals. . . .'"

Comment.—Concerning the Permanente Foundation, brief comment was made thereon in CALIFORNIA AND WESTERN MEDICINE *(December, 1942, on page 344). The Foundation was established by a loan from Mr. and Mrs. Henry Kaiser.*

"So the Permanente Foundation was founded by Henry and his wife, Bess Kaiser. This young Doctor Garfield might have all the figures to prove this was a wonderful investment, but the bankers were very pleased with Henry Kaiser's signature on the $250,000 loan."

Comment.—Reference has been made in a previous excerpt to the attitude of the bankers. Here it is shown that the banking fraternity were taking no chances in relation to the establishment of the Permanente Foundation. They protected themselves by having Mr. Kaiser sign on the dotted line. This is no reflection on the bankers. They are custodians of the money of citizens and are obligated to show proper caution in protecting the interests of their clients.

✓ ✓ ✓

"This immunity of doctors from really effective mass indignation was undoubted. And, during the past twenty years, their remarkable advances—for which we must thank the doctors—made medicine too costly for the common man. So it was inevitable, since the individual sick man must pay his doctor, that doctors will go where sick folks have the dough. This had brought about a maldistribution of medical care that stank to high heaven."

Comment.—Some readers may hold that the verb used in the past tense in the last sentence of the above could be used with even more justice to the author's comments as given in his last two sentences.

✓ ✓ ✓

"So the spread of these groups had remained feeble. Their number had remained small in proportion to the millions of our medical have-nots. And for a reason. From Chicago, headquarters of the American Medical Association, down through every state and county medical society from coast to coast, there reached an invisible but powerful hand. This hand was ready to give the works to any physician who'd go off the reservation by daring to serve a medical coöperative on a full-time salary.

"How, then, faced with the necessity of the medical care of 30,000 workers where the medical societies were powerful, would Garfield recruit a staff of good surgeons and physicians?"

Comment.—Whose is this "invisible but powerful hand" that de Kruif talks about as existing in the American Medical Association headquarters at Chicago?

In a long experience in organized medicine, the writer has yet to have his first experience with such an "invisible but powerful hand." The total number of licensed physicians in the United States is about 176,000. Component county medical societies are the sole judges of the conduct of their members and in such matters are independent of their respective state associations and also of the national organization.

The "invisible but powerful hand" myth is a figment of imagination held by persons not familiar with the facts.

For information concerning the second paragraph in the above excerpt, reference may be made to the article by the California Procurement and Assignment Service which appeared in CALIFORNIA AND WESTERN MEDICINE *for January, 1943, on pages 23-26.*

✓ ✓ ✓

"Shall the people have a say in how to pay their doctors? Or shall organized medicine dictate how physicians shall be paid? Or else, no doctor—even if you're going to die?"

Comment.—Do citizens dictate to merchants how they will decide to pay for goods purchased, or do merchants lay down the conditions of payment for their goods?

And the follow-up sentence in the excerpt, isn't it far-fetched?

"In the American Medical Association there are powerful constituent bodies, like the California Medical Association and the Michigan State Medical Society, that are actually fighting to bring about prepaid medicine."

Comment.—For these kind words, thanks.

* * *

"So with the national organization of our physicians. It is run by a few men in the little smoke-filled room. Of this fact the medical rank and file are not aware or to it they are indifferent. With this fact many of our most competent doctors are disgusted."

Comment.—The governing body of the American Medical Association is its House of Delegates. California is represented by eight delegates, who are elected by their California colleagues on the basis of the reputations for service which they have established. So also in other states. If "many of our most competent doctors are disgusted" with this plan of democratic organization, a better procedure will be welcomed.

* * *

"This was what haunted Garfield: the invisible hand from Chicago."

Comment.—Again, "the invisible hand from Chicago," Who, and What, and Why?

* * *

"Yet, if Garfield manned his Permanente Hospital with medical stumble-bums—always available a dime a dozen—his health plan was sure to fail. The hospital would jam up with sick people who would not get well. The workman would reject the health plan. Its income would dwindle. Kaiser would be left with that $250,000 note to which he had signed his name. And Garfield? He would be ruined."

Comment.—Author de Kruif here uses language not in keeping with dignified thinking or discussion. To apply the term "medical stumble-bums" to physicians whose services Doctor Garfield would reject, is out of place.

De Kruif insists that the physician in private practice is to have no money relations with patients, but financial considerations seem to be in order when the financial interests of Mr. Kaiser or Doctor Garfield are involved.

Referring to the California Procurement and Assignment Service report on the Permanente Foundation in CALIFORNIA AND WESTERN MEDICINE *for January, 1943, the following paragraph is quoted from page 24:*

"Doctor Garfield, according to these statements, is employed under an agreement which allows him to draw up to $25,000 annually in salary. To date, he states, he has drawn no salary from the funds of the Foundation, but has actually put into current operating funds some $10,500 of his own money. When and if the profit period of the Foundation is realized, it is anticipated that Doctor Garfield will draw his $25,000 annual salary, will be repaid his $10,500 advance and will have no further share in any profits accruing from the plan."

* * *

"Yet now, in spite of these sinister possibilities, Sidney Garfield began hiring highly trained young surgeons and physicians. He was quiet, but he was strangely persuasive."

Comment.—Concerning the hiring, the Procurement and Assignment Service report previously referred to stated:

"Early in its existence in California, Procurement and Assignment Service became aware of the building up by Mr. Kaiser and Doctor Garfield of a staff of physicians for both the industrial and nonindustrial medical care of Kaiser employees. The Kaiser staff of some thirty physicians (early in 1942) represented a group of young men, all but two of whom were definitely of military age.

"A review of the Kaiser medical staff showed that practically every one of the thirty physicians should be declared 'available for military service' because of his age; at the same time, Procurement and Assignment Service had no intention or desire to break up an established staff which was caring for an important segment of the industrial population. . . .

"At the same time, Procurement and Assignment Service put Doctor Garfield on notice that his staff members were vulnerable to induction into the Army by Selective Service because of their low average age. This warning was given for the protection of the staff, to obviate the disruption that might occur if a large part of the staff was classified 1-A by local draft boards and forced into military service." . . .

* * *

"This question of rooms versus wards during the terrific expansion of enrollment of workers on the health plan was a point of hot debate between Doctor Garfield and Henry Kaiser. The seventy-bed Permanente Hospital had no sooner opened in late August, 1942, than it was deluged beyond its capacity by the Kaiser army swarming up from its original 25, to 50, 70, 90,000 shipbuilders. Sidney Garfield—it was his duty as a doctor—wanted to take care of them all, rooms or no rooms. Henry Kaiser—fanatical believer in a medical golden rule—maintained that if he himself should have a private room, then so should every worker, down to the humblest laborer or shipyard sweeper."

Comment.—Hospital executives will find much of interest in the above.

* * *

"He [Henry Kaiser] got the $300,000 [more] without his signature [to an additional note]. It encouraged the bankers that, three months after the opening of Garfield's health plan, the original $250,000 loan was paying itself off at the rate of $25,000 a month!"

Comment.—Why it is possible to pay off a loan at that rate is easily understood when the income received in the Richmond shipyards and previously discussed is taken into consideration.

* * *

"Garfield offered his doctors salaries that ranged from $450 to $1,000 a month—not bad for a young physician or surgeon just out of hospital residency and facing the cold world of medical competition in individual practice. So between August, 1942, and March, 1943, Garfield's staff at the shipyard first-aid station, the Field and Permanente Hospitals had grown to a group of sixty well-trained physicians and surgeons."

Comment.—The Procurement and Assignment Service report previously quoted reflects interesting sidelights on the above.

* * *

"They [the doctors who were hired by Doctor Garfield] rubbed their eyes in amazement at Doctor Garfield's new medical economics. His organization's total income came, 40 per cent of it, from payment by industrial insurance companies for workmen's compensation insurance medical care. The remaining 60 per cent came from the individual 50 cents a week from the prepaid health plan voluntarily subscribed to by the Kaiser workers.

"Under this plan what could the doctors give the sick workers for their seven cents a day?"

Comment.—The above is given to emphasize the source of the Permanente Foundation's massive income of hundreds of thousands of dollars. With money received in such great amounts, it is not to be wondered at that Doctor Garfield is able to hire physicians on individual salaries running up as high as $1,000 per month.

* * *

"Of course their excellent salaries, with no overhead, are a good reason for the notably high enthusiasm and morale of Garfield's staff of doctors. But there is a deeper cause for their spirit that you remark about them on their rounds of medical mercy to the great army of the industrially wounded and the sick. On a vast scale it confirms Sidney Garfield's discovery made in the desert. There and at Grand Coulee he had begun to be thrilled by what happened to his doctors when the cruel barrier of money was lifted from between them and their patients. Exit dollars—enter God."

Comment.—When Author de Kruif refers to Doctor Garfield in the above, ending again with the sentence, "Exit dollars—enter God," how does he explain the "$25,000 annual salary" or more received by Doctor Garfield, referred to in the Procurement and Assignment Service report?

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"On this vast scale Garfield and his staff were demonstrating a revolutionary new medical economy. In the five months following the health plan's opening, the workers had paid $500,000 into the health plan; for this they had received the equivalent of more than $1,500,000 worth of treatment, when you estimate it on the fee-for-service system by which the individual pays his individual doctor."

Comment.—Along the same line of reasoning, and with the same fee-schedule estimations used in the Permanente computations above, it would be of interest to have the contrasting grand total of many millions of dollars that represent the value of the professional services gratuitously and unostentatiously given by California physicians in the county and other charitable hospitals of the State.

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"This weapon was the possibility of putting doctors who were stepping off the reservation of medical 'ethics'—into the Army. The Federal Procurement and Assignment Service had the duty to gather physicians for our armed forces. Now the officials of Federal Procurement and Assignment, and its state and local boards were—most of them—also high in political power in the American Medical Association and its constituent state and local societies. Of course, you see that fact's significance."

Comment.—The implication in the above might be called "nasty." The splendid group of physicians who as Medical Procurement and Assignment Service officers have given gratuitous service to our country deserve fullest commendation. That is the significant fact, not what de Kruif states.

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"The scientific medical teamwork, the swift mending of smashed skulls and broken bodies, the rapid diagnosis and cure of early pneumonia, the expert healing of burned eyes, the modern management of diabetes, high blood pressure, and wrecked hearts, the surgery of appendicitis, perforating stomach ulcers, and the scientific treatment of cancer—all this could not be done with men whose only qualification was a plain 'M. D.' Garfield's health plan was modern group medicine or it was nothing."

Comment.—What is modern hospital care if, in one sense, it is not "modern group medicine," where attending staff members confer with and utilize one another's knowledge and facilities in the treatment of seriously ill patients?

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"Now the physicians of California came to the rescue. Their leaders had smashed a cruel taboo by going out of their way publicly to approve Kaiser's prepaid medical care. Now in this emergency where illness, and even death itself, threatened hundreds of thousands of women and children, the California doctors awoke. Through their California Physicians' Service they believed they could undertake the care of this vast cohort of the medically forlorn."

Comment.—De Kruif gives to his book the title "Kaiser Wakes the Doctors." In the above he states "the California doctors awoke." California Physicians' Service was established several years before the Kaiser shipyards came into existence, and the California Medical Association contemplated the formation of California Physicians' Service even several years before that.

The California doctors, therefore, even according to de Kruif, evidently awakened themselves. The awakening did not come through Mr. Kaiser.

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"Now the California Physicians' Service was ready to go into death-fighting action. Before Pearl Harbor, its organization by California medical leaders had got the California Medical Association into the doghouse with the invisible hand that ran the American Medical Association."

Comment.—Again, the question is asked, To whom did this "invisible hand that ran the American Medical Association belong" that "got the California Medical Association in the doghouse"?

Members of the California Medical Association would be pleased to have this information, because they, themselves, know of no such power.

◆ ◆ ◆

"The workers—by their voluntary weekly fifty-cent pieces—not only paid for their care, but built those facilities themselves. That was the big news. It ought to thrill you doctors. You don't have to get your facilities by begging them from the rich; you don't have to get them by Government handout.

"Who'd manage the bookkeeping of this prepaid medical care? Industry, not the doctors, who don't pretend to be businessmen and admit it. Kaiser dealt his cards, face up, across the table."

Comment.—Wherein lies this difference in bookkeeping? Physicians have kept their own bookkeeping accounts for years. What bookkeeping magic is this which only "Industry, not the doctors," is able to manage?

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"Now in March, 1943, only six months after the Permanente Hospital had opened, came evidence of the mighty economic power of Garfield's prepaid group medicine. The sum accumulating from the individual seven cents a day from 60,000 Kaiser workers had not only paid for the upkeep and the lavish equipment of those hospitals. But, together with income from compensation insurance mandatory under California law, it was paying off the original sum advanced by Henry Kaiser for the building of the Permanente Hospital at a rate of $50,000 monthly. Within two years of that institution's opening, *the $550,000 needed to build and to equip it would be paid off in full.*

"This super-speedy self-liquidation was new in medical history. It dazed ordinary doctors, accustomed as they were to practice in hospitals that were tax-supported, or wallowing, because of their high overhead, in a morass of debt. It drew indignant bellows of unbelief even from certain eminent experts in prepaid medical care. Their incredulity was based not on any examination of the Kaiser health plan's bookkeeping. It came from a weakness common to all experts."

Comment.—In a previous page, de Kruif was making the payments to the bankers at the rate of $25,000 each month. Now it is up to $50,000 monthly. Would that de Kruif had also given information concerning salary lists and the reserves. A comparison of the administration expenses and "high overhead" would also be of interest.

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"Practicing individually, each doctor has to sell himself. This is obvious if he is to be successful. It results in the super-bedside manner, which has no relation to real medical ability. In the group the *organization* is the selling point. For instance, Mayo Clinic sells each doctor in the organization by *its* reputation. The doctor doesn't fritter away his time kidding John Smith by his bedside manner. He can devote his efforts to good medicine.

"Individual practice doesn't permit ready consultation. The waste of the patient's time in going from one medical building to another for each specialty is enormous."

Comment.—Not what one would call an excellent example of coherent thinking.

* * *

"Henry Kaiser believes that we can begin right now to build these Mayo clinics for the common man wherever there are industries. Even where the industrial units are small, their managers and their men can pool their efforts to build health-center hospitals that can be used in common. He is a great believer in good, not cut-throat, competition, and thinks the new prepaid group medicine will be stronger if its units are kept small."

Comment.—For other comment concerning the above, see in this issue the press item quoted in the editorial department.

* * *

"Garfield has calculated that community groups of 2,500 people can build, support, and pay off their hospital facilities.

"Then there are other 'experts' who wail that this may be all right in cities, but that it will be no go in rural regions where farmers notoriously have not got the ready money. Again Kaiser has the answer. The economic power of health plans of industrial regions is a tremendous one. When the hospitals there are paid off, then they will make formidable sums of money. . . . And this money can then overflow—with urban and rural citizens coöperating—to build small hospital health centers in rural regions.

Comment.—It is to be hoped that Mr. Kaiser, Doctor Garfield and those who hold to the above will put their plan into execution in two or three dozen places in California and other states.

* * *

"His [Kaiser's] heroes in tomorrow's new fight for life are the doctors. He looks forward to the return of a vast commando force of young physicians from the Army. They are no longer enthralled or misled by the reactionary double talk of organized medicine's invisible hand. They have practiced group medicine, *good* medicine, upon the soldiers and they know its beneficent power. Already they are laughing at the horse-and-buggy individualistic medicine of yesterday.

"The new hospital health centers will be the workshops where the power of the science of these young men will begin to work a fantastic transformation upon our nation now living, so large a part of it, half alive. The great economic power of the new prepaid medicine practiced in these health centers will give a new lease on life to our older doctors, too. Joining these health plans as the California physicians are now joining Kaiser's, there will be the wherewithal for them to become reëducated, to become teamworkers, happy that they, too, can join in the group medicine of our new fight for life."

Comment.—More will be known about all the above when colleagues now in military service return to take up work in civil practice.

The "invisible hand" evidently frets author de Kruif because here it is, bobbing up again.

* * *

"It [new hospital health centers and workshops] can abolish the misery and the insanity of women's change of life. By the skilled use of the new powerful hormones it can extend the sexual activity and lengthen the vigorous prime of life of men, so that we will no longer say that we grow old too quick and wise too late."

Comment.—Here Author de Kruif almost transposes himself into the rôle of an optimistic therapeutist.

* * *

"Large industries, groups of small ones, groups of doctors today left at home, the labor unions, the farmers' organizations—all should band together now to demand the Government Medical Loan Agency. This would guarantee to the local bankers 50 per cent of any losses which might come as a result of the banks' willingness to finance these new Mayo clinics for the common man.

"Then for tomorrow Kaiser sees a still brighter promise. 'How shall we reward the scores of thousands of young doctors who've risked their lives at the fighting fronts in the war?' he asks. 'Death has awakened these doctors.

"'We should urge that the Government provide them with an extra compensation, and special encouragement for the health centers that they will be ready and anxious to organize. The Government might well guarantee these returning doctors not 50, but 80 per cent of the cost of building their needed facilities.'"

Comment.—Author de Kruif evidently holds that the Government will be generous with doctors. How does he reconcile with his above sentiments the thirty-five-dollar fee table established by the Federal Children's Bureau which has been discussed in this and previous issues?

* * *

Here endeth the book review. G. H. K.

* * *

As a sample of the complimentary book reviews the de Kruif book is receiving, the following, which appeared in the San Francisco *Call-Bulletin* for October 7, is given space:

Books on Parade

"Kaiser Awakes the Doctors"

By Paul de Kruif

(Harcourt, Brace & Co., $2)

Henry Kaiser has done another tremendous job—he has provided medical care for his industries on the prepaid plan at the rate of 7 cents a day per person. Nothing is too good for the crudest laborer.

How Mr. Kaiser accomplishes this task is a stirring story of battles with bankers, and the American Medical Association, and of numerous problems in establishing a hospital. Fortunately he met young Doctor Garfield, who already had made a name for himself, for his hospital in the rugged desert country. Impressed by this project, Mr. Kaiser backed every idea he had for the Permanente Hospital, near Oakland, which is now a significant success.

Immediately absenteeism lessened and workers became more efficient. Mr. Kaiser says, however, "that they got more than efficiency—that they also got greater confidence and faith, and more courage." So now there is more than just the clanging and banging of steel that goes into a Liberty ship. There is the spirit of the men behind it.

"Kaiser Awakes the Doctors," by Paul de Kruif, is a dramatic and inspiring record of achievement.

* * *

Also, in connection with the foregoing excerpts from Author de Kruif's book, the following article, which appeared in the San Francisco *News* for October 7, may be of interest. Some of the statements which follow are very similar to thoughts expressed in the volume by de Kruif:

KAISER HOSPITAL ("CAN'T BE DONE") ENDS GOOD YEAR

(Nick Bourne, first newspaperman to go through the controversial Henry J. Kaiser nonprofit hospital, tells how the plan works and what the doctors have to say both for and against the experiment.—The Editor.)

By Nick Bourne

The nonprofit health plan "which couldn't succeed—the doctors won't stand for it" at the great Henry J. Kaiser shipyards at Richmond today ended its first year of providing unlimited medical and hospital care to 70,000 shipyard workers for 50 cents a week.

I went through the half-million-dollar hospital, interviewed the patients, nurses, and doctors, obtained the first year's financial statement and learned three things:

1. It works, at least during wartime.
2. Why it works.
3. What the patients and doctors think of it.

The plan, depression-born in the scorching Mojave Desert of California during Mr. Kaiser's work on the 900-mile Los Angeles aqueduct twelve years ago, has grown up by necessity of war in the teeming shipyards.

Largest United States Project

The year's statement of services rendered, money collected and spent, the gratitude of patients, growth of the organization and its imposing building, bespeak the wartime success of the venture, largest United States prepaid medical plan, according to A. L. Brodie, manager.

Each employee joining voluntarily pays 50 cents a week from his pay check. First year's payments, $1,229,331.52, bought 838 major operations, 4,652 minor operations, 47,024 days of hospitalization, 73,797 x-rays and many other services, including free medicine.

Doctors, mostly young Stanford University medical school graduates, do a mass-production, assembly-line job; receive salaries of $450 to $1,000 a month, depending on responsibility and seniority.

Payment in advance overcomes the human frailty of failing to provide for emergencies, according to Mr. Brodie. It has been estimated 40 per cent of Americans never pay for medical attention, they either never get it, or don't pay when they do.

Here is what the doctors on the job here think of the experiment:

Dr. William W. Saunders, x-ray department head, Stanford graduate: "I doubt if I would have the net income I receive here if I were in private practice. But I do three times a normal amount of work. I like it. I think we do our patients a good turn and they appreciate it. 'Outside' doctors don't like it; it's against the A. M. A. tradition to have patients assigned to a doctor.

Don't Sell Anything

Dr. Cecil C. Cutting, chief surgeon, Stanford, '35: "From the doctor's standpoint, the principal features are that the doctor does not have to be a businessman; has a close contact with associates in his own special field; doesn't have to worry over making a living or the patient's ability to pay his rent, his nurse, for his equipment; we can take each case to its logical conclusion regardless of cost.

"We don't have to sell anything except medical attention and are free to encourage research, progressive ideas, get the best facilities."

But some expressed misgivings:

"Dr. Noseglasses: "It may end up with Kaiser or some other businessman controlling the medical profession and deciding to pay all doctors $130 a month."

Dr. Black Moustache: "We are working toward an inescapable conclusion—Government-controlled 'socialized' medicine. That would get us into politics. Bureaucracy would halt progress."

Dr. Black Moustache: "This idea isn't new at all. It worked in Scandinavia for years."

"Up to Doctors!"

Dr. Van Dyke Beard: "It's up to the doctors, themselves, to control this system. If the doctors won't, business will and we may all be punching time clocks."

Dr. Baldhead: "Then we might join a union!"

The astonishing thing about the patients is that they usually are not very sick. They pay 50 cents a week for unlimited medical and hospital care and want to be sure to get their money's worth. One demanded that his dandruff be cured, or he'd quit. He was told he could hire a private physician or beauty specialist any time he wanted to.

"We do not get many ruptured appendices or advanced cases of pneumonia simply because they all flock in here (1,373,611 clinical calls during the first year) and we catch their trouble before it's serious," explained Dr. Cecil C. Cutting, chief surgeon.

I wandered down the corridors. No wards. All private or semi-private rooms, spotless, modern, with Venetian blinds.

Illness knows no color line here. Red-helmeted men, women welders, negroes, lined up for a checkup by the busy young doctors.

In one double room was Miss Katherine Rossi, shipyard loan office employee, here from Duluth, Minnesota, for six months; ill six months from skin trouble. A negro woman was in the adjoining bed.

"So help me!" declared Miss Rossi. "I've been in hospitals before, but never one like this. It's sure swell. I don't know what I would have done."

The doctors are working hard to keep the men building ships.

One summed up nonprofit medicine:

"The operation was a success—but the doctor died."—San Francisco *News*, October 7, 1943.

MEDICAL JURISPRUDENCE†

Hartley F. Peart, Esq.
San Francisco

A release given to a person whose negligence caused injury bars a malpractice action by the injured party against a physician for alleged negligent treatment which it is claimed aggravated the injury.

It is generally the law that where a person sustains injuries as the result of the negligence of a third person (for example, in an automobile accident) and thereafter consults a physician who further aggravates the injuries in the course of his treatment, the aggravation caused by the malpractice of the physician is considered an injury directly resulting from the original accident and the negligence of the third party. The injured person may, therefore, recover from the negligent third party any damages he suffers as a result of the physician's act.

This rule is subject to the qualification that, in the selection of a physician, the injured person must use reasonable care to choose a physician of ordinary competence and skill. If he does so, the law considers that he has one cause of action in which he may recover from the person first causing the accident for all damages he has suffered, even though some of the damage is directly attributable to the malpractice of the physician treating the injuries.

An application of this rule is illustrated by the case of *Ash* vs. *Mortensen*, 60 A. C. A. 286, decided August 13, 1943. The Court there denied the plaintiff recovery against a physician for malpractice, holding that a release of a cause of action against an automobile driver for personal injuries resulting from an automobile accident bars a subsequent recovery against a physician for alleged malpractice aggravating the injuries.

The plaintiff suffered comminuted fractures to the femur bones of both legs in an automobile accident. One month after the accident she filed suit against the operator of the car and recovered a judgment of $15,000. At the trial of the case the physician had testified that the plaintiff would not be able to walk normally for at least a year, that she might be crippled for life, and that there would be shortening of both legs. All of the testimony as to plaintiff's condition referred to her condition subsequent to her treatment by the testifying physician, and the jury was instructed that, in determining the amount of damages to be awarded plaintiff, they should consider not only the condition of the plaintiff at the time of the trial, but also her condition as it would exist in the future.

The operator of the car satisfied the judgment and obtained a full release from the plaintiff as to all claims arising out of the accident.

Thereafter, plaintiff filed suit against the physician who had treated her for the leg injury and who had testified at the trial, contending that he had failed to exercise ordinary care and skill and had carelessly treated the fractured bones. The defendant physician in his answer denied the alleged malpractice. In addition, he raised the affirmative defense that in the prior court action against the operator of the car, all elements of damage to the plaintiff had been considered and, therefore, the resultant judgment and satisfaction fully released and discharged not only the operator of the car, but also the physician from all responsibility for any damages sustained by the plaintiff. Even though the physician had not been a party to the prior action, the Court upheld this defense, ruling that the release given by the plaintiff to the operator of the car barred an action for malpractice against the physician who had treated plaintiff's injuries in an allegedly negligent manner.

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† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

The Court said:

"Plaintiff was at liberty to sue Wubben (operator of the car) for the damages she suffered in the automobile collision. But when she elected to sue him, her election was her decision to recover all damages resulting from his negligence and this included the aggravation to her injuries as a result of the physician's neglect. Having proceeded against Wubben, her judgment against that gentleman is a bar to her recovery against the doctors whose negligence might have aggravated the injuries received from Wubben's automobile. Evidence of plaintiff's condition subsequent to the treatment by defendants and her condition as it was anticipated in the future, must be deemed to have been a part of the basis of the jury's verdict."

The theory upon which the decision is based is that a person may not recover twice for the same injuries. Since the jury in the action against the operator of the car must be held to have considered her present condition and her anticipated future condition resulting directly from the accident and the alleged negligence of the physician, plaintiff had already recovered for all damages she had suffered.

In passing, it might be noted that this rule does not prevail in cases before the Industrial Accident Commission. In *Smith* vs. *Coleman*, 46 Cal. App. (2d) 507, the Court held that where an injured workman recovered damages for an industrial injury from his employer and insurance carrier before the Industrial Accident Commission, he could subsequently maintain an action for malpractice against a physician who had treated the injury.

LETTERS[†]

Concerning Medical Literature Sent to Military Camps in California—Letter of Appreciation:

Station Hospital
Camp Beale, California.
September 17, 1943.

California Medical Association,
450 Sutter Street,
San Francisco, California.

We received today by express the package of books and periodicals that the Association so generously sent us. We have a small library here at Camp Beale, but at the present time it is entirely inadequate for our needs. We certainly welcome any type of medical volumes and periodicals.

The Commanding Officer, Lt. Col. Charles H. Woodruff, wishes to personally thank the Association members for their thoughtfulness in helping to augment our medical library.

Sincerely yours,
(Signed) Alexander G. Bartlett,
Major, M. C., Chief of Medical Branch.

Concerning Obligations to Military Colleagues:

————, September 12.

Dear Doctor:

Your editorials in August California and Western Medicine just reached my desk.

I feel that upon behalf of all my fellow officers we owe you a vote of thanks for your thoughtful consideration of our problems.

In my position, I hear the gripes and learn of difficulties of medical officers, and your ray of sunshine for the future is a big help to these officers.

These men in overseas units who will soon depart for combat areas are not worried about what will happen to them in the Army, but are most concerned about what is to come after they return home, if they ever do. Many of them have expressed to me their bewilderment and have wondered if it wouldn't be better for them to start anew in another location so that they wouldn't be ever faced with the other civilian's practice. To see the stay-at-homes have all the business and to be compelled to live on the crumbs is more than they care to face. Having gone through it once before, I personally know how it will be.

I am, at this writing, officer of a 1,000-bed, . . . overseas general hospital. Our departure is not too long distant. We have a group of the finest officers in the Army. Men from the leading medical schools all over the country. We have eight American Board diplomates in the various specialties. Many are best men of their communities, professors in universities and chiefs of staff of large hospitals. The average age of our senior officers is 46.

Please know how much we appreciate what those of you who are understanding are doing for those of us who are in the service.

Sincerely,
....

Concerning Item on Scarcity of Women Physicians:

University of California
San Francisco, September 17, 1943.

Editor,
California and Western Medicine,
Addressed.

Dear Editor:

In your August issue, on page 128, is an excerpt from the *Berkeley Gazette* regarding the scarcity of women doctors to enter military service now that they are eligible to do so. According to the March, 1943 issue of the *Medical Woman's Journal,* there are 2,146 women doctors in practice within the required age limits acceptable for military service. It is not stated how many of this number would not be acceptable for military service because their present work is essential or because they have children under 16 years of age.

The Sparkman Bill was passed in April, 1943. There has not been a considerable length of time for the clearance of papers commissioning women up to July 1, and transferring those in the services they were then eligible to. Under the present medical emergency, I think a quotation from Dr. R. B. Spencer, Director of the National Cancer Institute, appropriate: "Our national policy has been shortsightedness and ungenerous toward women who have had the urge to make their social contribution in the field of medicine." We have a limited number of women acceptable in medical schools and frequently discourage their progress. Up until the passage of the Sparkman Bill a woman doctor was unable to do equal work for equal rank and pay in the military service.

Very truly yours,
(Signed) Isabella H. Perry, M. D.

[†] California and Western Medicine does no hold itself responsible for views expressed in articles or letters when signed by the author.

TWENTY-FIVE YEARS AGO[†]

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 10, October, 1918

EXCERPTS FROM EDITORIAL NOTES

Fourth Liberty Loan.—The Fourth Liberty Loan campaign, which opens on September 28, 1918, and closes on October 19, provides a field for direct war work which no patriotic practitioner can shirk.

The size of the loan, certainly six billion dollars, probably eight billion, is huge. No sum approaching it in proportions has ever been gathered for any purpose by any nation, nor at one time, by any group of nations. Until the Great War made the daily expenditure of hundreds of millions of dollars common, the mention of such a loan would have seemed the wildest fancy. . . .

Fifty Thousand Medical Officers.—With an army of three million men in the field in September, 1918, or in training and as contemplated, an expansion of this force to five million men, the Surgeon-General must have in the Medical Reserve Corps at least fifty thousand doctors. The Medical Reserve Corps must keep pace in growth with the army expansion and it behooves every doctor in the United States between the ages of 21 and 55, who is physically, morally and professionally fit, at the earliest possible moment, to arrange his personal affairs so as to offer his services to his country in the capacity of a medical officer. The United States is in the war to win and this can only be accomplished by a large and well-trained body of troops adequately cared for by a sufficient number of medical officers. The importance of the doctor's service and its relation to the successful outcome of the war cannot be overestimated. . . .

Volunteer Medical Service Corps.—To date [October, 1918] about 40,000 of the 144,116 doctors in the United States—not including the more than 5,000 women doctors—either are in Government service or have volunteered their services. Up to July 12 the Surgeon-General had recommended to the Adjutant-General 26,733 doctors for commission in the Medical Reserve Corps. About 9,000 others who applied were rejected. With the 1,194 in the Medical Corps of the National Guard and 1,600 in the Navy, the total—38,527—constitutes 26.73 per cent of the civilian doctors. Deducting those who declined their commissions or who have been discharged because of subsequent physical disability or other cause, the number actually commissioned in the Medical Reserve Corps stands (August 23) at 23,531, with several hundred recommended whose commissions are pending. Of the 23,531 there are 22,232 now on active duty. . . .

Important Change in United States Employment Conditions.—The supplying of war industries with common labor will be immediately centralized in the United States Employment Service of the Department of Labor, and all independent recruiting of common labor by manufacturers having a pay roll of more than one hundred men will be diverted to the United States Employment Service. This is in accordance with the decision of the War Labor Policies Board and approved by the President on June 17. (The War Labor Policies Board is composed of representatives of the War, Navy, and Agricultural Departments, the Shipping Board and the Emergency Fleet Corporation, the

(Continued in Front Advertising Section, on Page 18.)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA[†]

By N. F. SCATENA, M. D.
Secretary-Treasurer

Board Proceedings

The annual meeting of the Board of Medical Examiners will be held in Sacramento, California, October 18 to 21, 1943, at which time written examinations will be held for physicians and surgeons. Legal hearings are also scheduled for this meeting as well as hearings on petitions for restoration of certificates heretofore revoked, and on petitions for modification of terms of probation heretofore imposed.

An oral examination is scheduled to be held at the Board office in San Francisco on November 18, 1943, at 10 a. m.

News

"The State Board of Medical Examiners today announced those who successfully passed examinations for physicians, surgeons, chiropodists, and drugless practitioners, held in San Francisco in the last three months. The highest mark for physicians and surgeons—91 plus per cent—was made by Herbert N. Hultgren of San Francisco, a graduate of the Stanford School of Medicine. . . ." (San Francisco *Call-Bulletin,* August 28, 1943.)

"Urgent need for 600 women doctors who will be commissioned in the Navy in ranks from lieutenant commander to lieutenant (junior grade) was announced yesterday by the Navy's Bureau of Medicine and Surgery. They would enter the Medical Corps, not the Women's Reserve, and would serve in the United States, relieving men doctors for duty on war fronts." (Los Angeles *Times,* August 21, 1943.)

"Medical schools have speeded up their courses by condensing four years' work into three. Nearly 7,000 doctors a year are being graduated by the sixty-six approved schools." (Biggs *News,* August 27, 1943.)

Sulpha drugs may be prescribed by chiropodists in the treatment of the human foot, Attorney-General Robert W. Kenny ruled yesterday in an opinion to the Board of Medical Examiners." (Los Angeles *Examiner,* August 10, 1943.)

"More progress in science's fight to produce penicillin, the latest 'miracle drug,' was reported today by Dr. Charles E. Clifton, Stanford University bacteriologist. . . . Doctor Clifton, pondering how to produce the 'yellow magic' faster, thought he might be able to grow penicillin in a continuous flow somewhat similar to vinegar conversion. Laboratory experiments confirmed his ideas, and now the drug can be made continuously and at relatively great speed. . . ." (San Francisco *News,* September 10, 1943.)

"Attorney-General Robert W. Kenny today sought White House aid for the continuation of medical and nursing service to tenants of war-housing projects in California. Acting as the head of the California Housing and Planning Association, Kenny telegraphed President Roosevelt that a breakdown of the program is threatened through inability of the contracting Physicians' Service to continue under present financial arrangements. He asked the Presi-

(Continued in Back Advertising Section, on page 30.)

[†] This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

[†] The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

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CC. SIZE BOTTLE
No. 252A
BISMUTH SUBSALICYLATE
2 Grains (0.13 Gm.) in each CC.
Suspended in Oil
For Intramuscular Use
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Bismuth Subsalicylate N. N. R.

(IN OIL WITH CHLOROBUTANOL 3%)

Intramuscular Bismuth therapy is usually well tolerated by patients who react unfavorably or are resistant to arsenicals. It has been found effective in many other cases, when alternated with arsphenamine or as a substitute for mercury compounds. Average dose: One cc. weekly.

ACCEPTED AMERICAN MEDICAL ASSN

Bismuth Subsalicylate in Oil with Chlorobutanol 3% is supplied:

Special wide mouth ampule, 1 cc.;
2 gr. (0.13 gm.) in oil.
In boxes of 12, 25 and 100.
Wide mouth bottles, 60 cc.; 100 cc.; 480 cc.

Catalogue and Prices on Request

"ACCEPTED STANDARDS AT AN ACCEPTABLE COST"

CHEPLIN BIOLOGICAL LABORATORIES, INC.
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PREGNANCY
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Wasserman and Kahn tests as required by state law.

Blood typing to eliminate delay if transfusion is necessary.

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SAN FRANCISCO

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CADOL Capsules present a palatable, easy-to-take form of calcium phosphate and Vitamin D, and are indicated for supplementary use in deficiencies of either ingredient, as well as in pregnancy, lactation, etc.

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CADOL Capsules each contain:

Dibasic Calcium Phosphate........................7½ Grains
(Equivalent to approximately 116 milligrams elemental Calcium, and 90 milligrams elemental Phosphorus.)
Vitamin 'D'...750 U. S. P. Units

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CADOL Capsules are supplied in packages of 100, 500 and 1000

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ITEM No. 176

•

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278 Post Street San Francisco, Calif.

ALUM ROCK SANATORIUM
FOR DISEASES OF THE CHEST
SAN JOSE, CALIFORNIA

A small select sanatorium for the treatment of Tuberculosis and other chest diseases.

Each patient receives individual study and care. The referring physician receives regular clinical reports.

Climate is ideal. Located at 1,000 ft. elevation, 6 miles east of San Jose, overlooking the Santa Clara Valley. A folder will be sent on request.

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Philip H. Pierson, M.D., San Francisco
Glenroy N. Pierce, M.D., San Francisco
Ina Gourley, M.D., Oakland

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 24)

The menace of an epidemic in this city is very great, communication with the eastern centers is open and the disease there is rapidly increasing. . . .

The symptoms at the onset of Spanish influenza as recorded in the *British Medical Journal* dated July 27, 1918, are briefly given as follows: . . .

In times of epidemics every physician should consider himself a member of the staff of the Board of Health and every available facility of the Department is at his disposal.

Excerpt from Military News: A Message.—Each day every American soldier in France is confronted by a great duty. Our army there has a great task to perform for our country, for the world, for civilization, and for humanity. Our soldiers are doing their duty with a courage and fidelity and efficiency that thrill every heart. . . .

Progesterone in Oil.—For the treatment of certain cases of habitual or threatened abortion, dysmenorrhea and functional bleeding, E. R. Squibb & Sons, New York, have added Progesterone in Oil to their extensive line of hormone products. This is a sterile preparation of pure crystalline progesterone in corn oil for intramuscular administration, standardized in terms of International units. One I. U. is the progestational activity of 1 mg. of the crystalline standard.

Progesterone in Oil Squibb is supplied in ampuls containing sufficient material for the withdrawal and administration of 1 c. c. It is available in different sizes.

In the "Chronic Fatigue" of Mild Depression

After employing Benzedrine Sulfate therapy in a series of 40 patients diagnosed as suffering from nervous exhaustion, Nathanson concludes:

"In approximately 80 percent of the patients there was a marked amelioration of this symptom (fatigue). Many of the patients had complained of fatigue for long periods and had tried various types of treatment without benefit . . .

"A sense of increased energy and capacity for work was noted in more than half of the cases. In addition a feeling of exhilaration and sense of well being was a consistent effect . . . Many patients volunteered that there had been a definite increase in mental activity and efficiency." Nathanson, M. H.—J. A. M. A., 108:528, 1937.

Benzedrine Sulfate Tablets

Brand of racemic amphetamine sulfate

Benzedrine Sulfate is primarily useful in depressions characterized by apathy and psychomotor retardation, but is contraindicated in patients manifesting anxiety, hyperexcitability, or restlessness.

The use of Benzedrine Sulfate by normals should not be permitted; it should always be administered under the careful supervision of a physician; and depressive psychopathic cases should be institutionalized.

In treating depressed patients with Benzedrine Sulfate, the physician should bear in mind that any drug which produces pleasant or euphoric effects may prove to be habit forming—especially in unstable or neurotic individuals

SMITH, KLINE & FRENCH LABORATORIES
PHILADELPHIA, PA.

French Hospital

Geary Boulevard and
Fifth Avenue
SAN FRANCISCO,
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A general hospital of 225 beds operating an accredited School of Nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and operated by the French Mutual Benevolent Society through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons.

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Class "A" buildings affording every modern facility. Located in the quiet country 12 miles east of Long Beach. Classification of patients according to type of illness. Beautiful quiet gardens. Properly equipped for all types of shock therapy. For particulars address: Garden Grove Sanitarium, Garden Grove, Calif.

RICHARD A. CARTER, M.D.
Clinical Director

Resident Medical Staff

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 252)

dent's help in obtaining authorization for a new contract providing physicians and nurses." (Sacramento *Bee*, September 2, 1943.)

"With indications pointing toward a food crisis in California when the war is intensified against the Japanese in the Pacific theater, Governor Warren today appointed an eight-member state-wide committee on food and nutrition. The committee will hold its initial meeting at San Francisco tomorrow. . . ." (San Francisco *Call-Bulletin*, September 13, 1943.)

"Following litigation in the court since 1938 with a 'test case,' San Mateo today appeared to have the right to levy as a 'business license' a tax on professions as well as businesses in the city. The State District Court of Appeal yesterday upheld San Mateo's business license ordinance of 1932, together with its 1936 amendments, reversing a Superior Court ruling which declared the pact 'discriminatory' and, therefore, unconstitutional. The ordinance of 1932 was opposed by legal and medical men in San Mateo when, in 1936, an amendment was adopted charging a $15 base tax to professions, as well as businesses, and another $5 for each additional partner or employee. . . ." (Redwood City *Tribune*, July 13, 1943.)

"The California Supreme Court today denied a hearing to Casper L. A. Rinker, Los Angeles physician, whose license was ordered revoked by the State Board of Medical Examiners." (Los Angeles *Times*, August 18, 1943.)

(Continued on Page 32)

OUR CHANGING TIMES

THE whirl of events changes all of us. Our Association members have certainly been no exception. They observe the changes and they are making the best of them. Through careful training of new personnel, members of the California Association of Dispensing Opticians have learned how to maintain high medical standards of optical service during times of transition.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 30)

"A chiropractor and an osteopath yesterday were sentenced to two years in prison for conspiracy to violate the medical practice act, and their retrial on manslaughter charges was ordered by the court. Harry Navarre, D. C., and Dr. Leslie R. Nunn were charged with manslaughter following the deaths of Thomas Richmond, six, and John W. Childs, nine, from what was described as careless tonsillectomy." (Los Angeles *Daily News*, August 18, 1943.)

REPORT OF EXAMINATIONS

(Continued from Advertising Page 42, September)

NAME	SCHOOL
Klingel, Robert Wells *San Francisco*	Stanford U. Sch. of Med., '43
Knighton, Robert Syron *Los Angeles*	Coll. of Med. Evang., '43
Koford, Glenn Wesley *San Francisco*	Stanford U. Sch. of Med., '43
Kreutzmann, Walter Boese *San Francisco*	U. of Rochester Sch. of Med., '42
Lackey, Robert Warren *Sacramento*	Stanford U. Sch. of Med., '43
Langstroth, Lovell, Jr. *San Francisco*	Stanford U. Sch. of Med., '43
Lauer, Paul Richard *San Francisco*	U. of Mich. Med. Sch., '43
Layton, Walter Beatman *San Francisco*	Stanford U. Sch. of Med., '43
Lea, Austin William *Oakland*	Stanford U. Sch. of Med., '43
Leeds, Frank Howard *San Francisco*	U. of Calif. Med. Sch., '43
Levenson, Daniel *Fresno*	U. of Minnesota Med. Sch., '42
Lundstrom, Carl Harold, Jr. *San Leandro*	Northwestern U. Med. Sch., Ill., '42

(Continued on Page 34)

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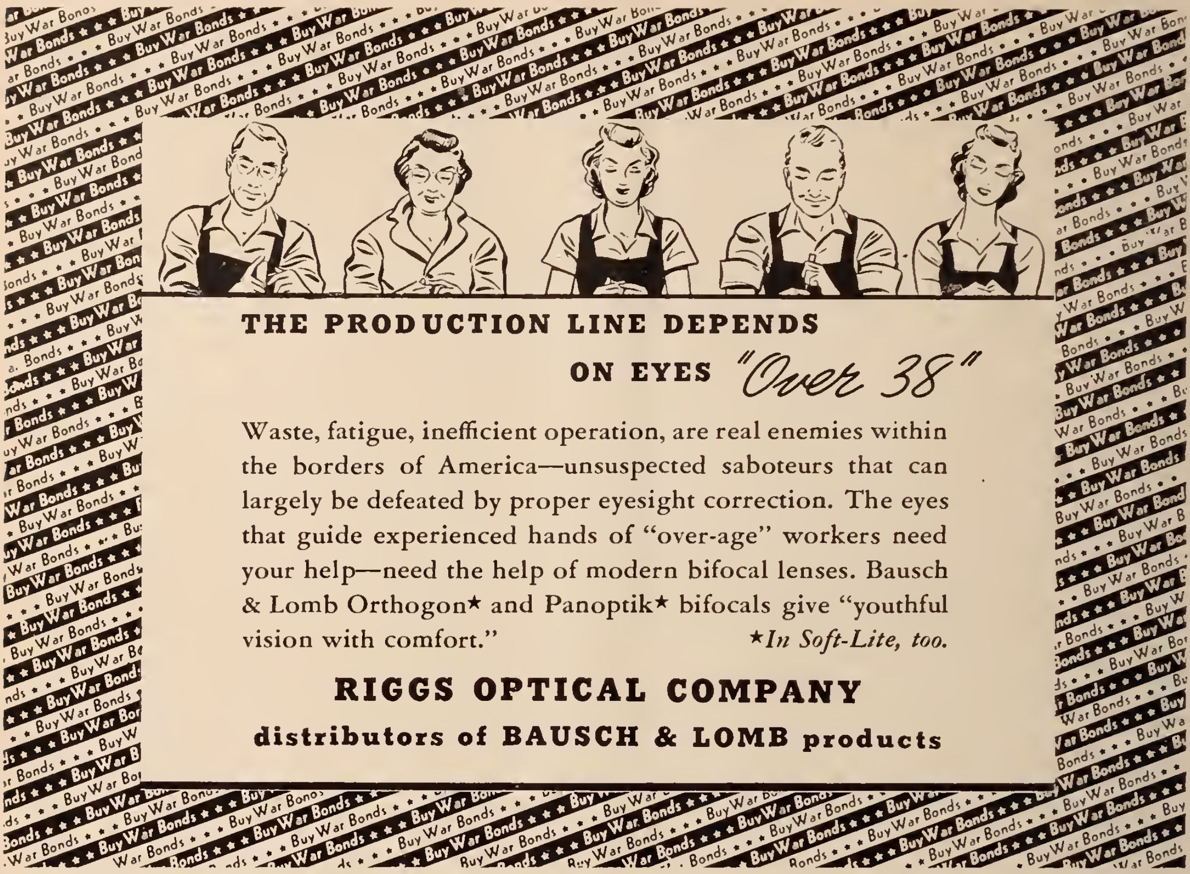

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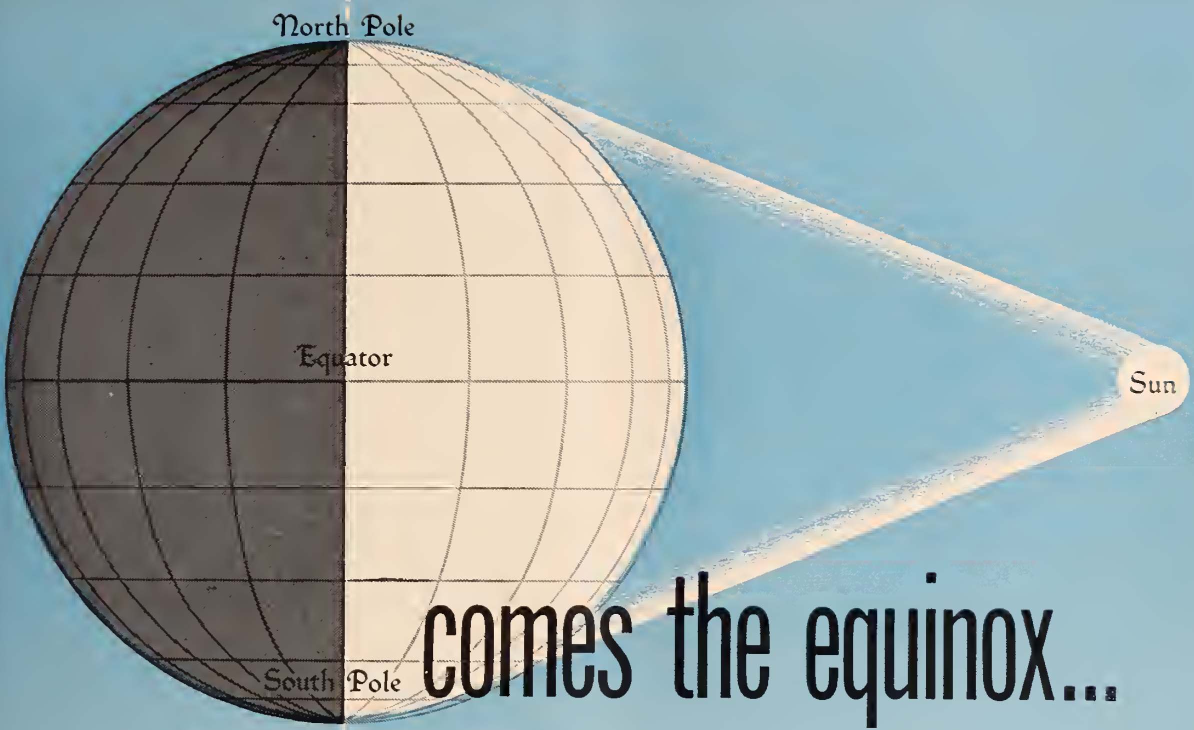
BOARD OF MEDICAL EXAMINERS

(Continued from Page 32)

NAME	SCHOOL
Lungren, John Charles *Long Beach*	U. of Pa. Sch. of Med., '42
MacLaggan, James Chester *San Francisco*	Stanford U. Sch. of Med., '43
Maino, Vernon Joseph *San Francisco*	Stanford U. Sch. of Med., '43
Markley, Richard Eugene *San Francisco*	U. of Colo. Sch. of Med., '42
McCann, William John *Watsonville*	Stanford U. Sch. of Med., '43
McKinney, Charles Leonard *San Jose*	U. of Calif. Med. Sch., '43
McMorrow, Clyde Henry *San Diego*	U. of So. Calif. Sch. of Med., '43
Meads, Manson *Berkeley*	Temple U. Sch. of Med., Pa., '43
Mellor, Norman Hoyt *Riverside*	St. Louis U. Sch. of Med., Mo., '42
Mense, Jackson Scheryer *Los Angeles*	Stanford U. Sch. of Med., '43
Mitchell, Robert James *Fresno*	Rush Med. Coll., Ill., '42
Mott, John Marshall, Jr. *San Francisco*	Stanford U. Sch. of Med., '43
Mouritsen, Holger Spaabeck *San Francisco*	Rush Med. Coll., Ill., '42
Mraz, Gerald Lincoln *Hanford*	U. of Okla. Sch. of Med., '41
Nelson, Phyllis Magdalene *San Francisco*	U. of Wis. Med. Sch., '41
Nichols, Walter Frederick *Pasadena*	Stanford U. Sch. or Med.,'43
Oakes, Robert John *Oakland*	U. of Okla. Sch. of Med., '42

(Continued on Page 36)



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BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

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O'Connor, Owen Jerrold *San Bernardino*	U. of Oregon Med. Sch., '43
Patton, Robert William *San Francisco*	Creighton U. Sch. of Med., Neb., '42
Pease, John Archibald *San Francisco*	Stanford U. Sch. of Med., '43
Pedemont, Leo Richard *Oakland*	Creighton U. Sch. of Med., Neb., '43
Peter, Frank John *Sacramento*	U. of Neb. Coll. of Med., '42
Peterson, Clarence Gray *San Bernardino*	U. of Oregon Med. Sch., '43
Picard, William Henry, Jr. *Oakland*	Stanford U. Sch. of Med., '43
Platt, John Henry *San Diego*	Stanford U. Sch. of Med., '43
Pope, James Bond *San Francisco*	Stanford U. Sch. of Med., '43
Porter, Bruce Merle *Oakland*	U. of Colo. Sch. of Med., '42
Porter, James Arthur, Jr. *Sacramento*	St. Louis U. Sch. of Med., Mo., '43
Raffel, Sidney *Palo Alto*	Stanford U. Sch. of Med., '43
Raimondi, Phillip Joseph *Sacramento*	U. of Marquette Sch. of Med., Wis., '43
Rappe, Chester Burnett *Los Angeles*	Northwestern U. Med. Sch., Ill., '43
Reynolds, Joseph William *Dunsmuir*	U. of Louisville Sch. of Med., Ky., '43
Rife, Robert Jacob *Oakland*	Stanford U. Sch. of Med., '43
Roach, Paul Applewhite *Los Angeles*	Stanford U. Sch. of Med., '43
Rosenstein, Ernest Simon *San Francisco*	Wash. U. Sch. of Med., Mo., '43
Ruff, Robert Franklin *Los Angeles*	Duke U. Sch. of Med., N. C., '43
Ryan, John Francis *San Francisco*	U. of Calif. Med. Sch., '42
Sandars, Leibert Jovanovich *San Francisco*	Rush Med. Coll., Ill., '41
Sandness, Justin Edward *Sanitarium*	Coll. of Med. Evang., '41
Schaeffer, Robert Case *Los Angeles*	Stanford U. Sch. of Med., '43
Schoff, Charles Edward, Jr. *San Francisco*	Stanford U. Sch. of Med., '43
Schultz, Norman Carter *Tucson, Arizona*	Stanford U. Sch. of Med., '43
Schumacher, James Charles *San Francisco*	St. Louis U. Sch. of Med., Mo., '36
Sehring, Maxine Moore *San Francisco*	Stanford U. Sch. of Med., '43
Siefert, Herman Jack *Oakland*	Stanford U. Sch. of Med., '43
Simmons, Donald Ray *Los Angeles*	Wayne U. Coll. of Med., Mich., '43
Smith-Swift, Gladys Grace *Hondo*	Coll. of Med. Evang., '41
Spaulding, Clarence Arthur *San Francisco*	Stanford U. Sch. of Med., '43
Staveren, Herbert Carl Max *San Francisco*	Stanford U. Sch. of Med., '43
Tanner, Joseph Blaine *San Francisco*	Stanford U. Sch. of Med., '43
Tatum, Howard James *San Francisco*	U. of Wis. Med. Sch., '43
Truax, Hugh Conrad *Los Angeles*	U. of So. Calif. Sch. of Med., '43
Walley, Orval Joseph *Long Beach*	Ohio State U. Coll. of Med., '42
Wilson, Lois Sawyer *San Francisco*	Stanford U. Sch. of Med., '43
Zappelli, Adolph Joseph *San Jose*	Creighton U. School of Med., Neb., '43
Zinn, Willard Jack *Fullerton*	U. of Calif. Med. Sch., '42

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Vitamin B Complex Award.—Nominations are solicited for the 1944 award of $1,000 established by Mead Johnson and Company to promote researches dealing with the B complex vitamins. The recipient of this award will be chosen by a committee of judges of the American Institute of Nutrition. The award will be given to the laboratory (nonclinical) or clinical research worker in the United States or Canada who, in the opinion of the judges, has published during the previous calendar year, January 1 to December 31, the most meritorious scientific report dealing with the field of the B complex vitamins. While the award will be given primarily for publication of specific papers, the judges are given considerable latitude in the exercise of their function. If in their judgment circumstances and justice so dictate, it may be recommended that the prize be divided between two or more persons. It may also be recommended that the award be made to a worker for valuable contributions over an extended period, but not necessarily representative of a given year. Membership in the American Institute of Nutrition is not a requisite of eligibility for the award.

To be considered by the committee of judges, nominations for this award for work published in 1943 must be received by the secretary, Arthur H. Smith, Ph.D., Wayne University College of Medicine, Detroit, by January 10, 1944. The nominations should be accompanied by such data relative to the nominee and his research as will facilitate the task of the committee of judges in its consideration of the nomination.

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The choice of a sedative for the sleepless patient is not alone dependent upon the rapidity of its action, but also upon the duration of action and how the patient feels when he awakens.

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Ipral Calcium (calcium ethylisopropylbarbiturate) in 2-grain tablets and in powder form for use as a sedative and hypnotic. ¾-grain tablets for mild sedative effect throughout the day.

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Penicillin: An Interesting Sidelight.—Part of the price of fame is an acute increase in the volume of one's incoming mail, of which some portion is certain to be on the screwy side.

Dr. Charles E. Clifton, Stanford bacteriologist whose discoveries in connection with the production of penicillin (the new "miracle drug") have received nation-wide publicity, has learned that. No sooner had *Time's* recent summary of his work been printed than the epistolary inflow started. Amateur biologists, with no laboratory facilities, no financial backing, and a total lack of laboratory training, but eager to help in a humanitarian way, were the first to take pen in hand. One such amateur asked for "some spores or other inoculum to start the cultures," seeing in that activity a chance to utilize his spare time in a recreational and helpful way.

Another, volunteering his collaborative services, wrote: "It so happens that I have access to a place in which articles of food when left for a very short period of time become moldy very rapidly." He described the mold as being the sort that sprouts long hair, beneath which the greenish material reposes. "What will take place next I do not know," he added. He also confessed to lack of any "chemical background of any kind." But he has access to plenty of table-bread scraps, and desires to help produce mold for sale to penicillin producers.

* * *

Another willing soul said in preface: "We know that sometimes an amateur by sheer accident stumbles across a process or invention which would entail much expense and research by regular scientific methods." He then reported having noticed a tremendous crop of mold in a garage where perishable goods are stored: "Unfortunately, not

(Continued on Page 44)

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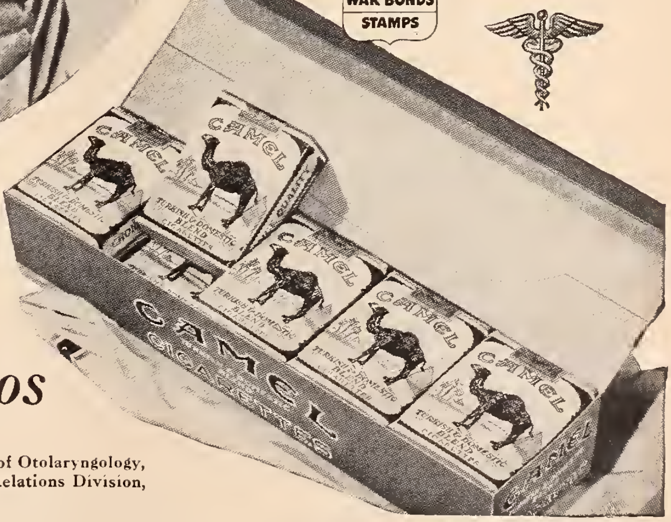

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New reprint available on cigarette research — Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York 17, N. Y.

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* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association. a nonprofit corporation of California, the sum of $———, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be paid to and become a part of the Physicians' Benevolence Fund of the California Medical Association as said fund is established and maintained by said Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I hereby give and bequeath unto the Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be expended by said corporation for the benefit and as a part of the Physicians' Benevolence Fund of the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California, for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association the following described real property situate in the county of ——— State of California, and more particularly described as follows, to-wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be held as a part of the Physicians' Benevolence Fund of the California Medical Association, the income whereof shall be used for the purposes of said fund as it is established and maintained by the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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* Correspondence for the Physicians' Benevolence Committee may be addressed to the C. M. A. office or to Axcel E. Anderson, Chairman, 1759 Fulton Street, Fresno.

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PENICILLIN: AN INTERESTING SIDELIGHT

(Continued from Page 40)

knowing about penicillin," he said, "I scraped, washed, and sunned the article. But have started a new crop and now take the liberty of sending you a sample." He said that moist earth, sawdust, or even horse manure, would produce the mold, which he believed he could harvest with a vacuum cleaner.

He explained that, naturally, he would expect to share in the profits, and quoted Scripture in justification of that hope.

A postscript said: "My credit rating is no good here as I have a cousin with the very same name and age, who don't pay his bills."

* * *

Doctor Clifton, rejecting those offers of aid, explains to the volunteers the reasons. Tens of thousands of bottles containing sterile media are required for the production of one pound of semi-pure penicillin, and over a ton of mold may be formed during the week's incubation at a carefully controlled temperature. Large and expensive installations are required, and permission must be granted by the War Production Board. To obtain that permission it must be possible to prove necessary financial support, technical personnel, and adequate experience in the field of biologicals.

The best opportunity to help, he points out, is to get a job with an established firm engaged in penicillin production.

* * *

More heart-touching are the appeals for penicillin from the sick and their intercessors, who grasp at this hope. But since the penicillin supply is inadequate for all cases, the

(Continued on Page 46)

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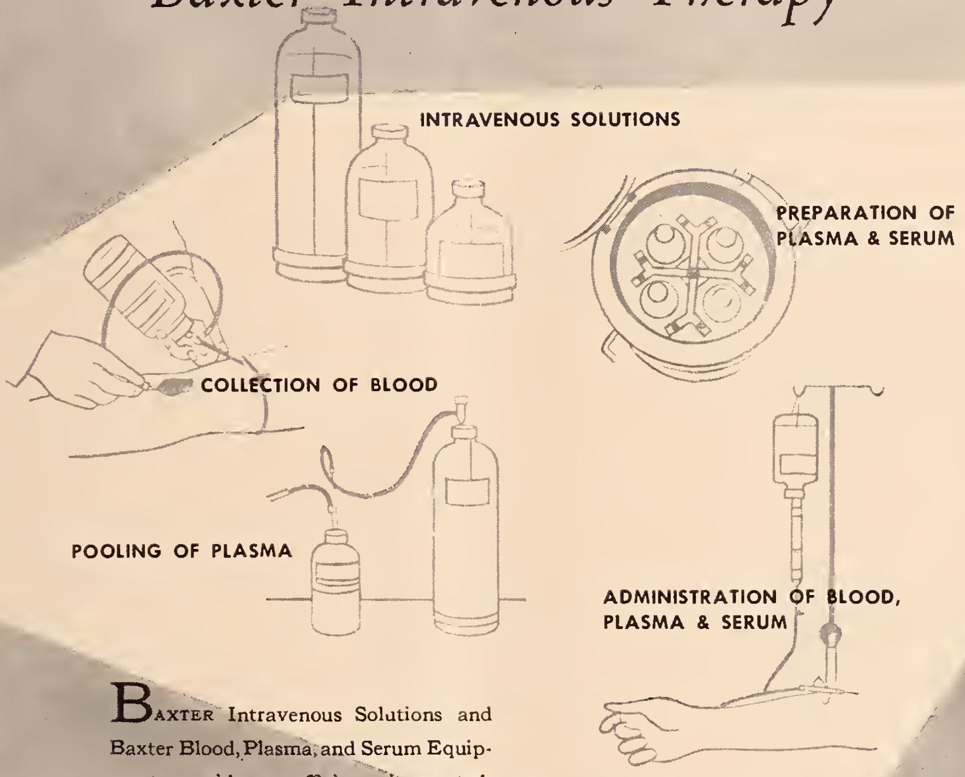
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PENICILLIN: AN INTERESTING SIDELIGHT

(Continued from Page 44)

War Production Board has restricted its use for the military forces alone. Civilians cannot get it without specific authorization from the Board.

A New York editor, touched by the plight of a very sick child, made a vigorous, political approach which brought such authorization for this case. The cure ensued. And the attendant publicity started things. Other political approaches, too, were made, with like result and more publicity. And the volume of appeals for special permit for other invalids gained space.

Except for the WPB curb on further exceptions, the result soon would be a diversion of the whole penicillin supply to the civilian population, while wounded soldiers and sailors would be denied the benefit of this drug that has proved so effective for preventing infection.

But the appeals continue. One woman, reporting that she had been sick all her life and had "tried everything" without result, said she had gone recently to the Mayo Clinic, where the diagnosis was that nothing ailed her, but that all she needed was to go to work. "I did," she reported, "I worked hard for a day or two, but it did no good."

So now she has hopes of being benefited by penicillin, provided, of course, she can get the consent of the WPB to have enough diverted from the military hospitals to herself, which, however, will not be possible.—"The Prowler." By Dallas E. Wood, in the Redwood City *Tribune*, September 21.

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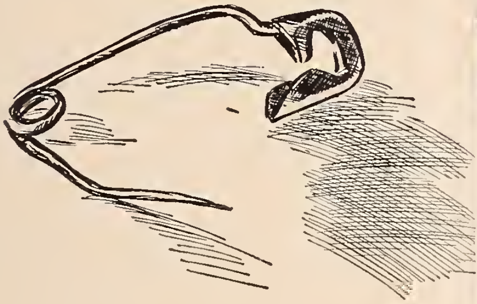

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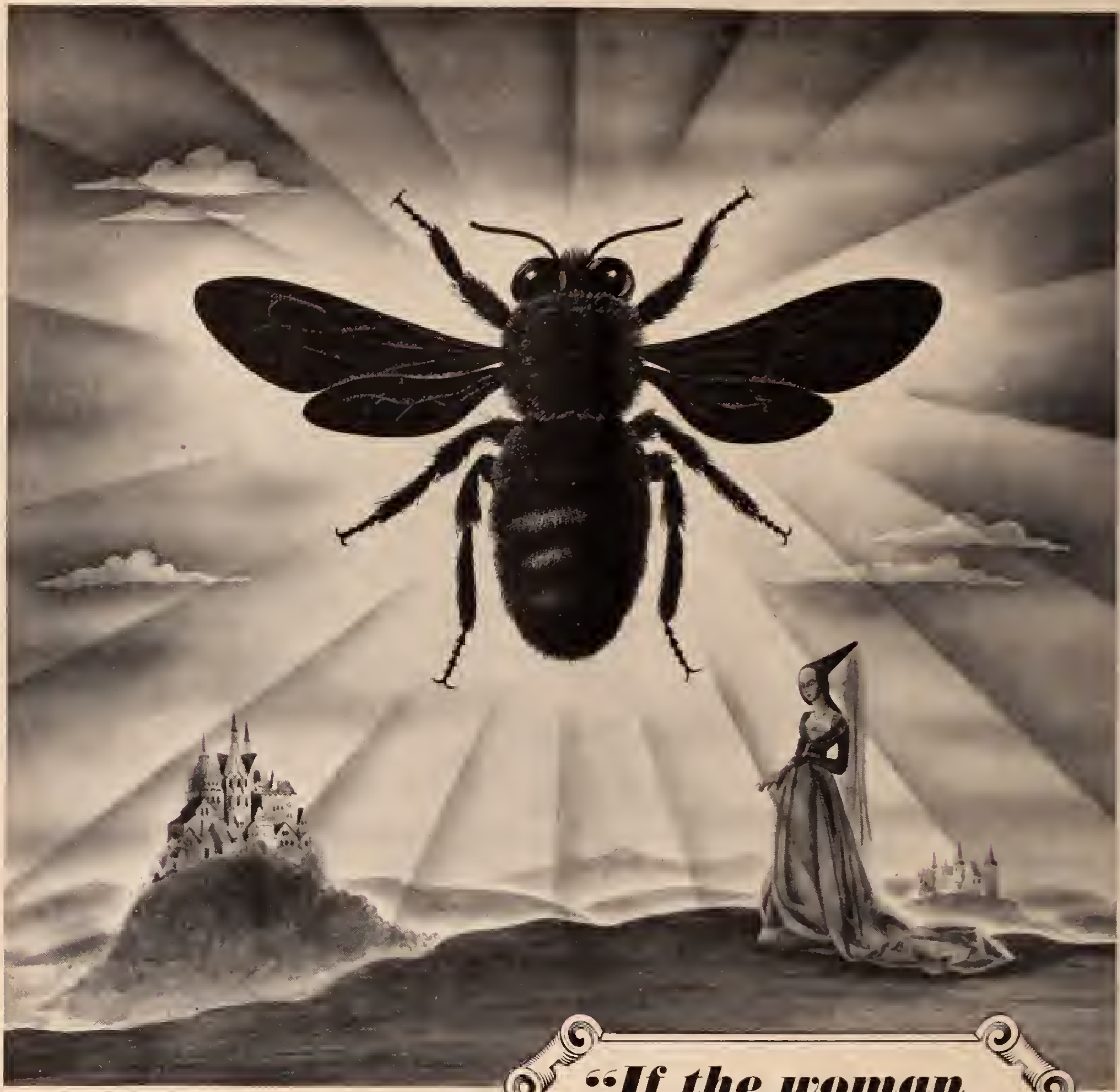

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*Himes, *Medical History of Contraception*

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(Continued on Page 5)

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A non-irritating Solution used as a nasal spray or drops

ISOPHRIN is ¼% levo-meta-methylamino-ethanolphenol hydrochloride, $C_9H_{13}O_2N.NCl$ in a special isotonic solution prepared only by Broemmel's.

A synthetic substance of epinephrine-like action, but possesses the advantage that it is more stable, its effects are prolonged and it does not irritate the nasal mucosa or cause sneezing.

Prolonged contact with certain metals may cause discoloration, therefore use spray bottles with only glass or hard rubber fittings.

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SAN FRANCISCO, CALIFORNIA

ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland

President, Clifford W. Mack, Livermore Sanitarium, Livermore.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
President, Charles E. Plumh, 310 Main Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Secretary, J. M. Boomer, American Trust Building, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, William G. Milholland, 711 Bank of America Building, Fresno.
Secretary, Jerome A. Thormann, 2607 Fresno Street, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Charles C. Falk, Sr., 507 F Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, T. E. Bartholomew, 319 Third Street, Calexico.
Secretary, Henry Forcher, 319 Third Street, Calexico.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, William I. Shultz, 408 N. Main Street, Bishop.
Secretary, J. Lloyd Mason, 135 East Line Street, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. M. Nicholson, Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, G. R. Fortson,* Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles

President, E. Vincent Askey, 2210 W. Third Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles*

Marin County Medical Society
President, Rodney B. Hartman, 38 Bigelow, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, John H. Lloyd, Fort Bragg.
Secretary, Louise E. Petty, Talmage.
Meeting, *On Call.*

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Rollin Reeves, 32 E. San Luis Street, Salinas.
Secretary, S. Condit Glasgow, 8 E. Alisal Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth,* Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, D. A. Harwood,* 2145 Walnut, Santa Ana.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Edward S. Babcock, 1127 Eleventh Street, Sacramento.
Secretary, Carl E. Burkland, 510 Medico-Dental Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Kenneth L. Dole, Medical Arts Building, Redlands,
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
President, W. Don Rolph, 640 National Avenue, National City.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Sidney J. Shipman, 490 Post Street, San Francisco.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Curtis M. Galt, 134 N. Lincoln Avenue, Manteca.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. F. Ragsdale, 717 Twelfth Street, Paso Robles.
Secretary, Harrison Eilers, Box 360, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, William A. Key, 23 Second Avenue, San Mateo.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, J. Irving Beattie,* 652 E. Santa Clara Street, San Jose.
Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
President, F. P. Shenk, Medico-Dental Building, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President*

Shasta County Medical Society
President, Oscar Jess Hansen, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Clifford M. Carlson, 576 B Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, 107 Crescent Road, San Anselmo.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, Frank L. Doane, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, G. C. Coffey, Bank of America Building, Ventura.
Secretary, M. M. Raines, 34 North Ash Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Ray E. Nichols, Woodland.
Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, John W. Lindstrum, 423 Fourth Street, Marysville.
Secretary, Joseph J. Salopek, 423 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

(Roster lists continued on advertising page 6)

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* Deceased.

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ITEM No. 40

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(Continued from Page 3)

Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 364 Fourteenth Street, Oakland, 12; 153 Kearny Street, San Francisco; 675 East Santa Clara, San Jose.

Hospital Service of Southern California, 743 South Grand View Street, Los Angeles.

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento.

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco. Phone WEst 8000.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles. Phone Fitzroy 7694.

Note.—The Library of the American Medical Association, 535 North Dearborn Street, Chicago, Illinois, also maintains a medical literature packet service.

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John W. Budd, M.D.*
A. H. Warner, Ph.D.*
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* *In Military Service*

OFFICERS OF SCIENTIFIC SECTIONS, CALIFORNIA MEDICAL ASSOCIATION

Members who contemplate presentation of scientific papers should promptly address the secretary of the proper section, as per addresses which follow. Correspondence concerning scientific exhibits, and medical and surgical films, should be addressed to the Chairman of the Committee on Scientific Work: George H. Kress, M. D., 450 Sutter, San Francisco.

Anesthesiology

Chairman, Evelyn H. Case, 374 Thirty-fourth Street, Oakland.
Secretary, C. Eugene Schuetz, 6253 Hollywood Boulevard, Hollywood.

Dermatology and Syphilology

Chairman, Irving R. Bancroft, 711 South Harvard Boulevard, Los Angeles.
Vice-Chairman, John Fanning, 1127 Eleventh Street, Sacramento.
Secretary, Chris R. Halloran, 1052 West Sixth Street, Los Angeles.

Eye, Ear, Nose and Throat

Chairman, George McClure, 411 Thirtieth Street, Oakland.
Vice-Chairman, Lewis F. Morrison, 490 Post Street, San Francisco.
Secretary, Walter R. Crane, 1026 Roosevelt Building, Los Angeles.

General Medicine

Chairman, Mast Wolfson, 215 Franklin Street, Monterey.
Secretary, John Martin Askey, 1930 Wilshire Boulevard, Los Angeles.
Assistant Secretary, Salvatore Pablo Lucia, 2898 Broadway, San Francisco.

General Surgery

Chairman, J. Norton Nichols, 1930 Wilshire Boulevard, Los Angeles.
Secretary, Leon Goldman, University of California Hospital, San Francisco.
Assistant Secretary, Eugene J. Joergenson, 1200 North State Street, Los Angeles.

Industrial Medicine and Surgery

Chairman, Richard O. Schofield, 1027 Tenth Street, Sacramento.
Secretary, John E. Kirkpatrick, Shasta Dam Hospital, Shasta Dam.

Neuropsychiatry

Chairman, J. S. Kasanin, 2200 Post Street, San Francisco.
Secretary, Clarence W. Olsen, 312 North Boyle Avenue, Los Angeles.

Obstetrics and Gynecology

Chairman, Philip H. Arnot, 490 Post Street, San Francisco.
Vice-Chairman, Roy E. Fallas, 1930 Wilshire Boulevard, Los Angeles.
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Chairman, H. A. Edmondson, 1200 North State Street, Los Angeles.
Vice-Chairman, James F. Rinehart, University of California Hospital, San Francisco.
Secretary, R. H. Osborne, 312 North Boyle Avenue, Los Angeles.
Assistant Secretary, James B. McNaught, 2398 Sacramento Street, San Francisco.

Pediatrics

Chairman, William C. Deamer, University of California Hospital, San Francisco.
Secretary, Howard R. Cooder, 3875 Wilshire Boulevard, Los Angeles.
Assistant Secretary, Charles W. Leach, 2000 Van Ness Avenue, San Francisco.

Radiology

Chairman, Roy W. Johnson, 1407 South Hope Street, Los Angeles.
Secretary, Earl R. Miller, University of California Hospital, San Francisco.

Urology

Chairman, Arno G. Folte, 870 Market Street, San Francisco.
Secretary, Paul A. Ferrier, 65 North Madison Avenue, Pasadena.

California Medical Association Delegates and Alternates to the American Medical Association

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Edward N. Ewer, Oakland	(1943-1944)	Robert T. Legge, Berkeley
William H. Kiger, Los Angeles	(1943-1944)	Donald G. Tollefson, Los Angeles
Robert A. Peers, Colfax	(1943-1944)	Frederick N. Scatena, Sacramento
William R. Molony, Sr., Los Angeles	(1943-1944)	Ralph B. Eusden, Long Beach
Dwight L. Wilbur, San Francisco	(1944-1945)	L. R. Chandler, San Francisco
Lyell C. Kinney, San Diego	(1944-1945)	Bon O. Adams, Riverside
Lowell S. Goin, Los Angeles	(1944-1945)	Leo J. Madsen, Santa Monica
Henry S. Rogers, Petaluma	(1944-1945)	Robert S. Stone, San Francisco

Special Committees

Physicians' Benevolence Committee

Axel E. Anderson, Chairman	Fresno
Elizabeth M. Hohl	Los Angeles
Robert A. Peers	Colfax

Woman's Auxiliary to the California Medical Association

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President, Mrs. C. C. Landis, 1081 Woodland Avenue, Chico.
President-Elect, Mrs. Ralph Eusden, 4360 Myrtle Avenue, Long Beach.
First Vice-President, Mrs. Franklin Farman, 622 North Bright Avenue, Whittier.
Second Vice-President, Mrs. Raleigh W. Burlingame, 147 Arlington Road, Redwood City.
Recording Secretary, Mrs. Laurence K. Gundrum, 1539 Oak Grove Avenue, San Marino.
Treasurer, Mrs. Richard B. McGovney, 64 Glendessary Lane, Santa Barbara.
Corresponding Secretary, Mrs. Hollis Carey, 210 Hazel Street, Gridley.

County Presidents

Alameda County—Mrs. Stanley R. Truman, 1054 Ashmount Ave., Oakland.
Butte County—Mrs. J. O. Chiapella, 318 Sowillena Ave., Chico.
*Contra Costa County—Mrs. S. M. Weil, Box 188, Rodeo.
Fresno County—Mrs. W. E. Richard Schottstaedt, 4929 Wilson Ave., Fresno.
Humboldt County—Mrs. W. J. Quinn, 231 Brett St., Eureka.
Inyo-Mono County—Mrs. Lloyd Bambauer, Box E, Bishop.
*Kern County—Mrs. C. I. Mead, 2830 18th St., Bakersfield.
Lassen-Plumas County—Mrs. Fred J. Davis, Jr., Susanville.
Los Angeles County—Mrs. Wm. J. Molony, Jr., 2050 Balmer Drive, Los Angeles.
Marin County—Mrs. Alex Miller, 911 Mission Ave., San Rafael.
*Merced County—Mrs. Fred O. Lein, 100 21st St., Merced.
*Monterey-San Benito County—Mrs. H. M. Stufflebam, Acacia St., Salinas.
Orange County—Mrs. F. Harold Gobar, Fullerton.
Riverside County—Mrs. Newman K. Bear, 2410 Prince Albert Dr., Riverside.
Sacramento County—Mrs. Wm. F. Harding, 2951 26th St., Sacramento.
San Diego County—Mrs. Edwin Hal Kelley, 3650 8th Ave., San Diego.
San Francisco County—Mrs. Norman Morgan, 2290 Vallejo St., San Francisco.
San Joaquin County—Mrs. Yale Brady, 222 Davis Place, Stockton.
*San Luis Obispo County—Mrs. Horace Hagan, 1333 Mill St., San Luis Obispo.
San Mateo County—Mrs. Logan Gray, 520 Aragon Drive, San Mateo.
*Santa Barbara County—Mrs. R. J. Brines, Hope Ranch, Santa Barbara.
Santa Clara County—Mrs. John C. Wilson, 1640 University Dr., San Jose.
Santa Cruz County—Mrs. M. J. Marquess, 36 Washington St., Santa Cruz.
Siskiyou County—Mrs. F. W. Martin, Mt. Shasta.
*Solano County—Mrs. H. Brownlie Perkens, 41 El Camino Real, Vallejo.
Sonoma County—Mrs. Alexis Maximov, 265 Talbot Ave., Santa Rosa.
*Stanislaus County—Mrs. Phillip Von Hugen, Rt. 2, Box 23, Escalon.
*Tulare County—Mrs. L. L. Seiligman, Dinuba.
Ventura County—Mrs. Wm. Fellerbaum, 825 Ojai Rd., Santa Paula.

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* Auxiliaries not heard from as yet this year.

Miscellaneous California Medical Organizations

Department of Public Health of the State of California

San Francisco—603 Phelan Building, 760 Market Street, San Francisco; UNderhill 8700.

Sacramento—631 J Street.

Los Angeles — State Office Building, 217 West First Street, MAdison 1281.

President, Elmer Belt, Los Angeles.

Director, Wilton L. Halverson, 603 Phelan Building, 760 Market Street, San Francisco.

California Northern District Medical Society

President, John H. White, Chico.
Secretary, J. Homer Woolsey, Woodland Clinic, Woodland.

Board of Medical Examiners of the State of California

San Francisco—Room 214, 515 Van Ness Avenue.

Los Angeles—906 State Building.

Sacramento — Business and Professional Building, 1020 N Street.

Secretary, Frederick N. Scatena, M. D., 1127 Eleventh Street, Sacramento.

Southern California Medical Association

President, Ray B. McCarty, 3116 Main Street, Riverside.

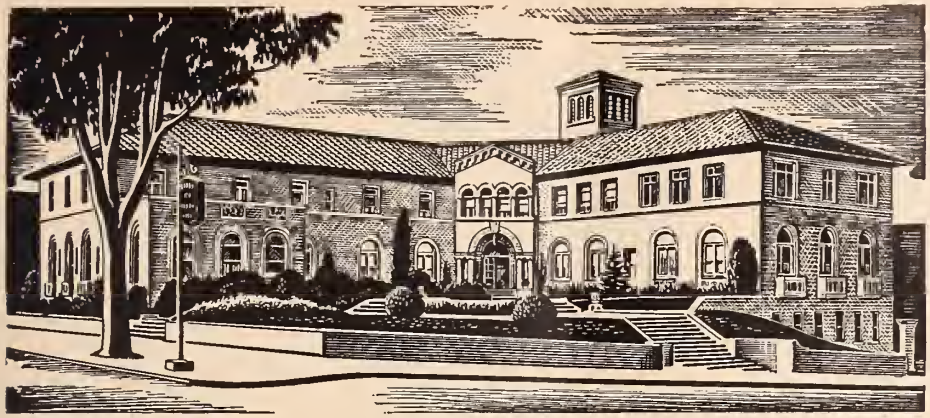
Secretary, Nelson Paul Anderson, 2007 Wilshire Boulevard, Los Angeles.

The Public Health League of California

Executive Secretary, Ben H. Read, San Francisco office, 251 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PROspect 5711.

Medical Schools of California

University of California Medical School, Third and Parnassus, San Francisco. Francis S. Smyth, M. D., Dean.
Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean.
University of Southern California Medical School, 1100 North Mission Road, Los Angeles. B. O. Raulston, M. D., Dean.
College of Medical Evangelists, 312 North Boyle Avenue, Los Angeles. Walter E. Macpherson, M. D., President.



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BOOK REVIEWS

BOOKS RECEIVED

A Surgeon's World. An Autobiography. By Max Thorek, M. D. Cloth. Price, $3.75. Pp. 410. Philadelphia, New York: J. B. Lippincott Company, 1943.

Personal and Community Health. By C. E. Turner, A. M., Sc. D., Dr. P. H., Professor of Public Health in the Massachusetts Institute of Technology; formerly Associate Professor of Hygiene in the Tufts College Medical and Dental Schools; sometime Member of the Administrative Board in the School of Public Health of Harvard University and the Massachusetts Institute of Technology. Seventh Edition. Cloth. Price, $3.50. Pp. 585, with illustrations. St. Louis: The C. V. Mosby Company, 1943.

Clinical Diagnosis by Laboratory Examinations. By John A. Kolmer, M. S., M. D., Dr. P. H., Sc. D., LL. D., L. H. D., F. A. C. P., Professor of Medicine in the School of Medicine and the School of Dentistry of Temple University; Director of the Research Institute of Cutaneous Medicine; formerly Professor of Pathology and Bacteriology in the Graduate School of Medicine of the University of Pennsylvania. Cloth. Pp. 1239, with illustrations. New York, London: D. Appleton-Century Company, 1943.

Synopsis of Tropical Medicine. By Sir Philip Manson-Bahr, C. M. G., D. S. O., M. D., F. R. C. P. Senior Physician to the Hospital for Tropical Diseases, Royal Albert Dock and Tillbury Hospitals; Consulting Physician in Tropical Diseases to the Dreadnought Seamen's Hospital, London; Director, Division of Clinical Tropical Medicine, London School of Hygiene and Tropical Medicine; Consulting Physician to the Colonial Office and Crown Agents for

(Continued on Page 10)

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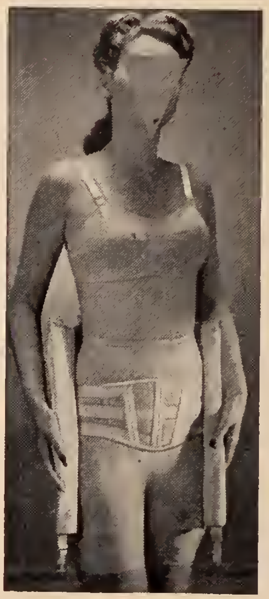

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BOOKS RECEIVED

(Continued from Page 7)

the Colonies; Consultant in Tropical Medicine to the Admiralty and to the Royal Air Force; Lumleian Lecturer, Royal College of Physicians, 1941. Cloth. Price, $2.50. Pp. 224 with 5 plates. Baltimore: The Williams & Wilkins Company, 1943.

A Hundred Years of Medicine. By C. D. Haagensen and Wyndham E. B. Lloyd. Cloth. Price, $3.75. Pp. 444. New York: Sheridan House, 1943.

Body Poise. By Walter Truslow, M. D., F. A. C. S., Consulting Orthopedic Surgeon to the following hospitals: Brooklyn, Long Island College, St. John's, Norwegian, Victory Memorial, Evangelical Deaconess, Kingston Avenue, St. Giles, Brooklyn, N. Y., and Pilgrim State, Brentwood, N. Y.; former Lecturer on Orthopedic Surgery, Long Island Medical College and on Anatomy and Kinesiology, New York University, New York School of Physical Education and Y. M. C. A. Summer School, Silver Bay, N. Y. Cloth. Price, $4.50. Pp. 312, with illustrations. Baltimore: The Williams & Wilkins Company, 1943.

The Compleat Pediatrician. Practical, Diagnostic, Therapeutic, and Preventive Pediatrics. Fourth Edition. For the Use of Medical Students, Internes, General Practitioners, and Pediatricians. By Wilburt C. Davison, M. A., D. Sc., M. D., Professor of Pediatrics, Duke University School of Medicine, and Pediatrician, Duke Hospital. Formerly Acting Head of Department of Pediatrics, The Johns Hopkins University School of Medicine, Acting Pediatrician in Charge, The Johns Hopkins Hospital, and Member American Board of Pediatrics. Fellow American Academy of Pediatrics and American College of Physicians, Member American Pediatric Society, and Division of Medical Sciences, National Research Council. Cloth. Pp. 256. Durham, N. C.: Printed by Seeman Printery for Duke University Press, 1943.

Life Is Too Short. An Autobiography by C. Kay-Scott (Frederick Creighton Wellman). Cloth. Price, $3.50. Pp. 348. Philadelphia, New York: J. B. Lippincott Company, 1943.

BOOK REVIEWS

Reconstructive Surgery of the Eyelids. By Wendell L. Hughes, M. D., F. A. C. S., Hempstead, New York. Cloth. Pp. 160, with illustrations. St. Louis: The C. V. Mosby Company, 1943.

The original ideas evolved by Hughes on reconstruction of the eyelids has appeared in the periodical literature and has already been of much service to plastic surgeons. This definitive monograph gives a systematic and amply illustrated presentation, and includes a critical analysis of previous work in this field, a complete bibliography, and a detailed index. The publication during the present conflict is most timely, as reconstruction of the eyelids is often a sight-saving measure as well as of obvious cosmetic importance.

J. E. L.

Atlas of Obstetric Technic. By Paul Titus, M. D., Obstetrician and Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; Secretary, American Board of Obstetrics and Gynecology. Cloth. Price, $7. Pp. 180, with illustrations by E. M. Shackelford, Medical Illustrator, John C. Oliver Memorial Research Foundation, St. Margaret Memorial Hospital, Pittsburgh. St. Louis: The C. V. Mosby Company, 1943.

This book is a companion book to Titus' *The Management of Obstetric Difficulties.* The number of illustrations (471) gives a clue to the intent of the book, namely, to illustrate by means of detailed pictures the various steps in obstetric technic. In addition, there are short, concise sentences describing the various steps in technic. There are fifteen sections to the book, and at the end of each section there is inserted a blank page for the purpose of making notes.

(Continued on Page 14)

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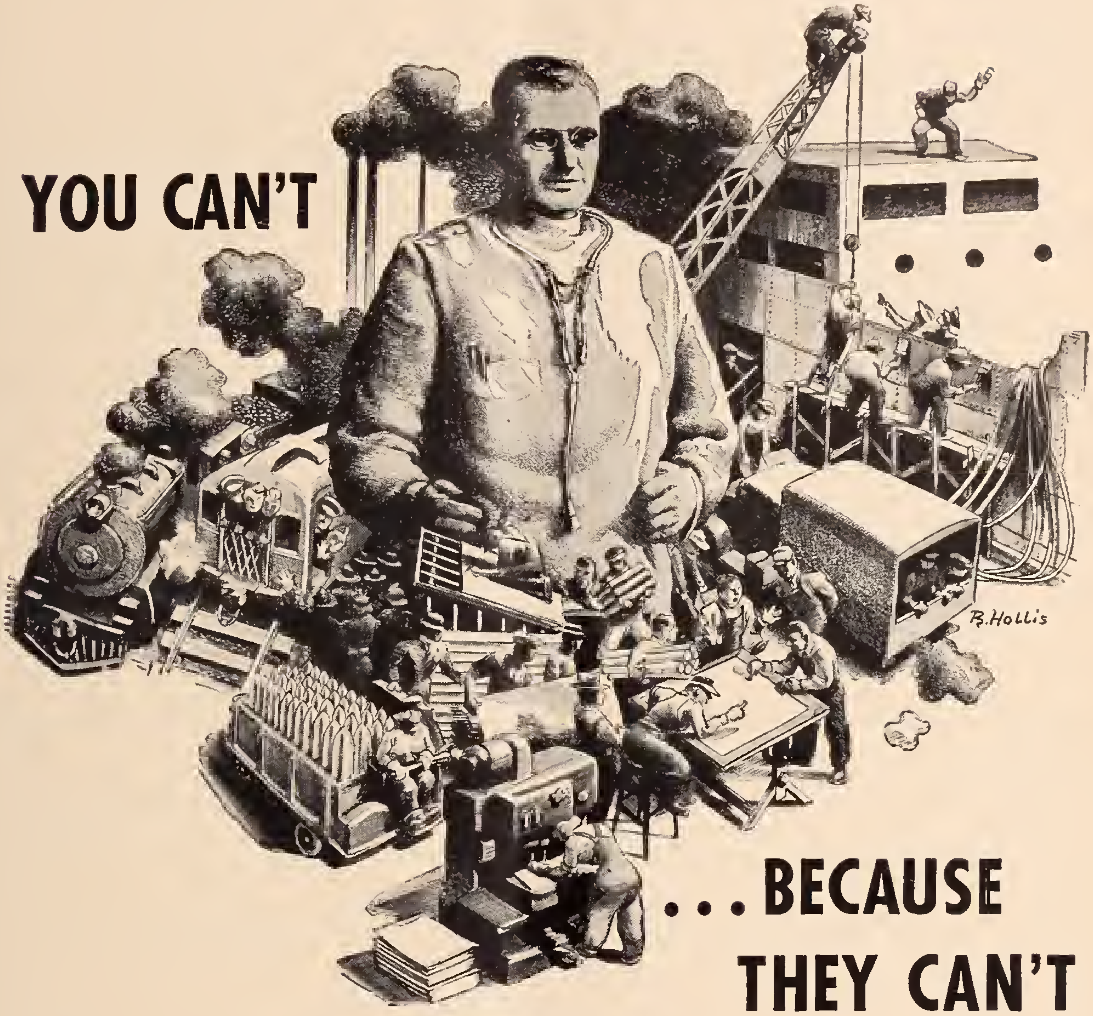

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BOOK REVIEWS

(Continued from Page 10)

If one remembers that neither *The Management of Obstetric Difficulties* nor the *Atlas of Obstetric Technic* is intended to be a textbook, one can find no fault with either book. The teaching of obstetrical procedures by illustrations is a much more satisfactory method of teaching than by description. The book fully meets the requirements for which it was intended and should find a place on the library shelf of every general practitioner who does obstetrics.

A. M. VOLLMER.

Diseases of the Nose, Throat and Ear. By William Lincoln Ballenger, M. D., F. A. C. S., Late Professor and Head of the Department of Otology, Rhinology and Laryngology, School of Medicine, University of Illinois, Chicago; and Howard Charles Ballenger, M. D., F. A. C. S., Associate Professor of Otolaryngology, Northwestern University School of Medicine, Chicago; Surgeon, Department of Otolaryngology, Evanston Hospital, Evanston, Illinois. Eighth Edition, thoroughly revised. Cloth. Price, $12. Pp. 975, illustrated with 604 engravings and 27 plates. Philadelphia: Lea & Febiger, 1943.

After careful perusal of the contents of this volume, one finds it impossible to improve on its description in the publishers' prospectus. It thoroughly covers all of the problems concerned with the practice of Otolaryngology. It includes also an excellent description of the Lempert technique. The material is presented in a manner which is most instructive to one in General Practice, and at the same time complete for the one who limits his practice to Ear, Nose and Throat work. Many of the fanciful theories found in the ordinary book of this type have been eliminated, and only the concrete factors pertinent to each subject have been retained.

(Continued on Page 17)

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BOOK REVIEWS

(Continued from Page 14)

Proctology for the General Practitioner. By Frederick C. Smith, M. D., M. Sc. (Med.); F. A. P. S., formerly Associate in Proctology, Graduate School of Medicine, University of Pennsylvania; Fellow, American Proctologic Society; Editor, The Weekly Roster and Medical Digest, Philadelphia County Medical Society; Editor, The Medical World; Lieutenant Colonel, Medical Reserve Corps, United States Army. Second Revised Edition. Cloth. Price, $4.50. Pp. 466, 161 illustrations. Philadelphia: F. A. Davis Company.

The text on Proctology as edited by Frederick C. Smith, M. D., M. Sc. (Med.), F. A. P. S. Philadelphia, supplies, in a very excellent manner, a good practical working knowledge of anorectal disturbances.

The general practitioner, and especially the general surgeon, is surely becoming more conscious of the need of more definite and up-to-date knowledge of the pathologic entities in and around the anus and rectum. This relatively short text covers the important conditions, or those most frequently encountered, in such a plain, understandable fashion that it should, to a large degree, prevent many of the more usual pitfalls of anal-rectal diagnosis and treatment and serve as a very valuable guide or reference.

The Author's remarks in the chapters on "History Taking" and "Diagnosis" are very pertinent and interesting—so different and instructive in contrast to the usual grist of material found in the complete text on Proctology.

The subject of "Hemorrhoids" is very thoroughly covered and includes the various methods of treatment, both injection and surgical, as well as preoperative and postoperative care and even the anesthetic of choice.

The subject on "Malignancy of the Anus and Colon" is very nicely handled. The extreme importance of making a

(Continued on Page 18)

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BOOK REVIEWS

(Continued from Page 17)

careful diagnosis in all cases of anorectal bleeding is stressed as this is the most common, and sometimes the only symptom, of malignancy in this region, causing it to be recognized early enough to effect a possible cure.

H. C. Anderson.

Diseases of the Breast. By Charles F. Geschickter, M. A., M. D., Lieut. Commander, Medical Corps, United States Naval Reserve; Director of The Francis P. Garvan Cancer Research Laboratory; Pathologist, St. Agnes Hospital, Baltimore. With a Special Section on Treatment in Collaboration with Murray M. Copeland, A. B., M. D., F. A. C. S.; Instructor in Surgery, Johns Hopkins Medical School; Visiting Surgeon and Assistant Oncologist, University Hospital, University of Maryland Medical School; Visiting Oncologist, Baltimore City Hospitals. Cloth. Price, $10. Pp. 829, with 593 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

Diseases of the Breast by Geschickter, published by J. B. Lippincott Company, 1943, is a comprehensive study of diseases, tumors, inflammation and malformation of the breast. One who has followed the literature of breast tumors, particularly, is at once attracted to this volume, as the preface states that the basic material is from the work of Halsted, Welch, Bloodgood, Dean Lewis and the author.

Careful investigation of breast tumors was begun at Johns Hopkins by Halsted and Welch fifty years ago and a few years later the work on the Halsted radical operation for carcinoma was published. Bloodgood continued this work and later showed that the surprisingly good results of the Halsted radical operation were due to the fact that several cases thought by Halsted to be malignant and included in his series were not malignant or mildly so.

Bloodgood also did a lot of work on non-malignant conditions of the breast, particularly fibro-cystic mastitis, and first straightened out our ideas about this trouble.

All of this work is reviewed.

The author continued investigation of breast conditions in conjunction with Dean Lewis and did a great deal of work in the rôle of endocrines in breast conditions.

While his opinions in general are based on the work done at Johns Hopkins, the opinions of other competent clinicians and pathologists are presented. For instance, the opinions regarding the relationship of fibro-cystic mastitis to malignancy, etc. No change has occurred in regard to the necessity of a radical procedure in an operable breast cancer and this conclusion is backed by a large group of cases followed for at least ten years.

While of particular interest to surgeons, those with some considerable knowledge of breast conditions, the work should be of great or greater value to gynecologists, obstetricians and internists who do not see these entities so frequently. The subject matter is well balanced as regards the importance of the condition, and the illustrations, both clinical and microphotographic, are profuse and excellent.

There is a bibliography after each chapter and the literature has been thoroughly reviewed.

The text is easy to read and the book is compact and of convenient size.

This is a very definite addition to the surgical literature of the last five years and should be in every medical library as well as those of the individual collector

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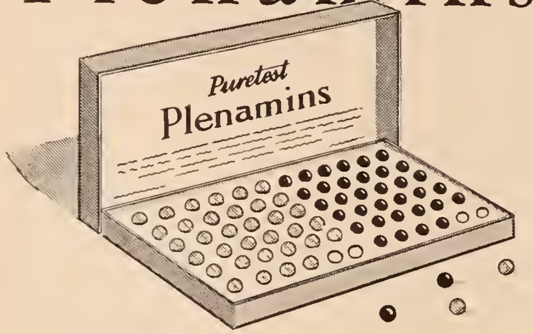

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 300)

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From on Article on "Treatment of Syphilis of the Central Nervous System," by Richard W. Harvey, M. D., Son Francisco.—My object in presenting this paper is to discuss the treatment of lues of the central nervous system with the emphasis on vigor and thoroughness. We all know how discouraging has been the prognosis and how inadequate our treatment. I insist that we have lacked woefully in thoroughness of treatment, and in recognizing that every case of primary lues holds the potentialities of central nervous system lues; and it is in the early stage that we should begin treatment, and force it heard. . . .

From an Article on "Radium in the Treatment of Uterine Cancer with Case Reports," by Rex Duncan, M. D., Los

(Continued on Page 24)

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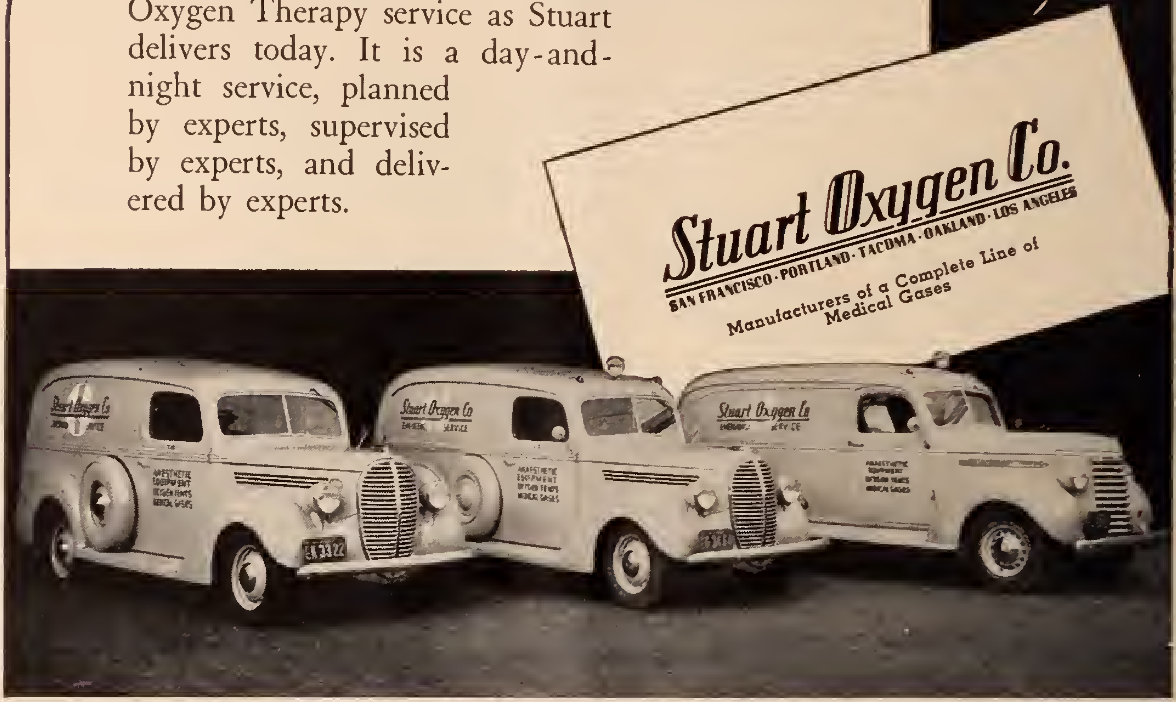
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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

Angeles.—When we consider that more than 25 per cent of the cases of cancer of the uterus are so advanced as to be inoperable when seen by the surgeon, and that more than 60 per cent of those operated have recurrences, we are confronted with a serious question as to the treatment of these cases comprising a large majority of the total. . . .

From an Article on "The X-ray Treatment of Uterine Fibroids," by Henry J. Kreutzmann, M. D., San Francisco.—The Secretary of the Gynecologic Section, Dr. Alfred Baker Spaulding, suggested to me to present a paper on x-ray treatment of fibroids of the uterus at this meeting; and in response to this suggestion, I have the honor to make the following report.

Before I begin my paper proper, I have to offer an apology for making to you, surgeons as most of you are, a plea for non-surgical treatment of uterine fibroids. I am quite aware that in the last decade the operative procedures for the eradication of this ailment have been rendered extremely safe and simple; I have, myself, operated in several hundreds of such cases; yet I felt quite interested in this most modern treatment for various reasons, and I shall render to you a short account of my valuation of this mode of treatment based on my own observations. . . .

From an Article on "A Study of the Lung Reflexes in Pulmonary Tuberculosis," by F. M. Pottenger, M. D., Monrovia, California.—The reflex is the means by which tissues and organs react to their surroundings. A reflex is due to an impulse which is carried over a sensory neuron to its cell in the central nervous system, where it is transmitted either directly or through other nerve cells and their fibers

(Continued in Back Advertising Section, Page 28)

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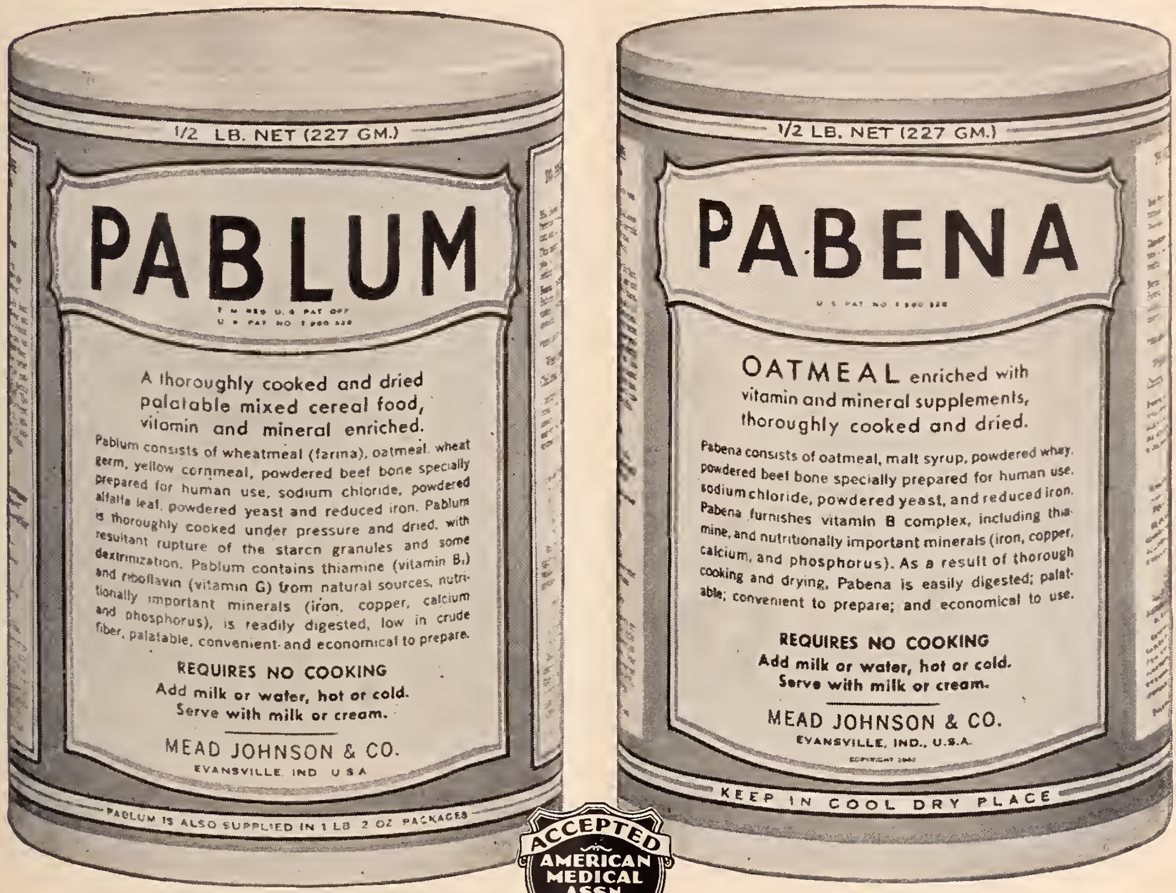
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EDITOR . . . . GEORGE H. KRESS

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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C. M. A. department, see index below.)

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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

SURVEY OF CALIFORNIA MEDICAL AND HOSPITALIZATION GROUPS: REPORT AND RECOMMENDATIONS OF LIAISON COMMITTEE OF CALIFORNIA MEDICAL ASSOCIATION COUNCIL

The Mannix Survey.—On February 7, 1943, the Executive Committee of the California Medical Association voted to invite John R. Mannix, of the Michigan Medical Service, to make a survey of California Physicians' Service and the three Blue Cross hospitalization groups operating in California (Hospital Service of California, Oakland; Hospital Service of Southern California, Los Angeles; and Intercoast Hospitalization Insurance Association, Sacramento). For minutes of that meeting, which appeared in CALIFORNIA AND WESTERN MEDICINE for March, see item 12 on page 130. Mr. Mannix secured a leave of absence from his Michigan group, came to California, made the survey, met with the Council, and in due course submitted his detailed report. With certain changes, his report was approved and placed on file (see CALIFORNIA AND WESTERN MEDICINE for July, item 10 on page 75). The revised report by Mr. Mannix—"Voluntary Health Plans in California"—appears in full in this current issue of CALIFORNIA AND WESTERN MEDICINE, on pages 258 to 265. It should be read.

* * *

The Liaison Committee.—A special Liaison Committee was appointed by the Council to bring in a report on the next steps in procedure, the Committee's recommendations appearing in the current number of the OFFICIAL JOURNAL, on page 273. The hope is expressed by the Council that all members of the California Medical Association will take the time not only to read the text of Mr. Mannix' report, but also carefully to scan the recommendations of the Liaison Committee which are to be found in the minutes of the Council meeting held on October 10, 1943 (see item 6 on page 273). It would be in order to have the reports here referred to made the subject of special consideration at the next meetings of each of the California Medical Association's forty component county medical societies. The Liaison Committee (Dr. John Cline, Chairman, San Francisco; Dr. Frank A. MacDonald, Sacramento; and Dr. Edward B. Dewey, Pasadena) will be glad to receive suggestions. Letters can be sent to them direct (their addresses appear on advertising page 2), or may be forwarded to the Association Secretary, 450 Sutter Building, San Francisco, for transmittal.

At this time it may be stated that the members of the Council of the California Medical Association—who have given many hours of thought to conditions and complications which have arisen in California medical and hospitalization service activities—urge again upon all who have special responsibilities in these matters to keep in mind the importance of the issues at stake. The outlook approach should take into consideration not only the immediate present, but the days yet to come. Let past misunderstandings be relegated to the rear. The question is, how to bring about a unification of endeavors that will more thoroughly promote the fundamental objective of offering to California citizens who belong to the lower income bracket groups, the best medical and hospitalization service available, and at costs within the financial resources of those citizens. If the give-and-take spirit is displayed in broad-minded manner, a happy solution of the major problems should be possible.

MATERNITY-PEDIATRIC PROGRAM OF THE FEDERAL CHILDREN'S BUREAU AND ITS MANDATORY FEE SCHEDULE AND OTHER REGULATIONS

Rules and Regulations of the Federal Children's Bureau Are At Fault.—Because of its deficiencies, the maternity-pediatric program discussion brought into being by the Federal Children's Bureau—through its regulations which, in essence, place in operation in most portions of the United States a mandatory below-cost fee schedule for professional services rendered to wives and infants of enlisted men—will not down. As further California evidence on this point, the attention of readers is directed to the resolutions approved by component county medical societies of the California Medical Association, some of which appeared in the September number on page 178; others, more recently adopted, appearing in this issue on pages 282-284, and 293.

It is as difficult as ever to explain why the lay executives of the Federal Children's Bureau and their medical subordinates should have deemed it proper to inflict upon a profession—whose members, both in the armed forces and in civilian practice, have made for themselves such an exceptional record of generous and wholehearted service to our country and fellows—a compulsory schedule of fee payments and other regulations through a method that may be characterized as a sort of backdoor entrance for socialized medicine.

In discussions concerning adequate medical care, it is always a source of wonderment to physicians why certain lay welfare reformers and their governmental co-workers fail to appreciate that some of their supposedly altruistic designs and improvements for "bigger and better medical service" will not do other than result in "lesser and worse medical service" for the very citizens for whom they claim they are working!

* * *

Autocratic Expression of Paternalistic Power.—The maternity-pediatric program of the Federal Children's Bureau is a case in point. Our country is at war. The objective of adequate professional care for the wives and infants of enlisted men is an aim to which all alike give full accord. Nevertheless, it is apparent that members of the medical profession find themselves at a disadvantage in opposing the method of payment for the professional services rendered, as put forth by the Federal Children's Bureau of the United States Department of Labor. Under existing conditions, when its plans are criticized or opposed, it is an easy task for a bureaucracy to apply the smear brush of nonpatriotic coöperation. It is all the more regrettable that a small group of persons in a lay governmental bureau—with or without the wholehearted consent of their medical associates and advisors—can be given the power to decide for a group of some 150,000 doctors of medicine the exact amount and procedures in service and payment for stipulated prenatal, confinement, and postpartum care. However, it is a consoling thought to know that it is one thing to give a manifestation of such arbitrary power, and another, to maintain it to the end. In this instance, time will show, especially so, since the program can be maintained only through repeated deficiency bill appropriations by Congress, in the consideration of which the objections of physicians to the Federal Children's Bureau's autocratic rulings may very properly be called to the attention of Congressmen.

* * *

Letter of Council to California Medical Association Members.—The principles at stake in the Federal Children's Bureau plan have such important relationship to the maintenance of proper standards in obstetric and pediatric work that the Official Journal of the California Medical Association can follow no other course than to keep the members of the Association acquainted with developments as they arise. For those who are interested, reference should be made to recent maternity and pediatric items (Items XXXI to XXXVII) which appear in this issue on pages 282-284, and 293.

Special attention is called to the letter dated October 22, addressed to the members of the Association (see Item XXXI on page 282), in which the course of action for individual physicians, as interpreted by the California Medical Association Council, is outlined. For double emphasis, the following excerpts are here presented:

> The Council of the California Medical Association did not change its action previously taken wherein the decision concerning participation in the Federal Children's Bureau plan was left to individual members of the State Association. In regard thereto, the situation is as follows:
>
> 1. The California Medical Association has expressed approval of the objective to provide adequate maternal-pediatric care to the wives and infants of enlisted men;
>
> 2. The Council of the California Medical Association has *not* given approval to the regulations of the Federal Children's Bureau whereby the payments *must* be made to the attending physician;
>
> 3. Members of the California Medical Association are free agents in this work; each physician to decide for himself under what conditions he is willing to give the indicated professional services.
>
> Since the physician has the privilege of deciding for himself whether he will or will not participate in the plan

outlined by the Federal Children's Bureau, the following additional information is given:

(*a*) A physician is at liberty to sign Part II of the prospective mother's application (which she obtains from a local board of health, the same being a State Board of Health form), but in so doing, the physician obligates himself to give the professional services stipulated for the money consideration also outlined. Further, the physician agrees that he will not accept additional compensation for the said services from the patient or patient's family. Provided, that services rendered prior to the day the prospective mother signed the application, or for services not stipulated in the prenatal, confinement and postpartum agreement, may be charged against the patient. (It is important that the physician read the agreement and inform himself concerning the services he will be called on to render before he signs a prospective mother's application.)

(*b*) Members of the California Medical Association are also free to determine for themselves whether they will accept such patients as private patients, under agreements mutually agreeable between patient and physician; but in such cases the physician must refrain from signing the agreement which the health boards give to prospective mothers who make request therefor.

However, if this latter course of a personal arrangement is followed, it is important to remember that the prospective mother will not be entitled to hospitalization. (Note: However, if the attending physician accepts no remuneration for himself, his patient will be entitled to hospitalization.)

* * *

Resolutions of Five of the Pacific States.—Attention of readers is also called to the resolutions adopted by representatives of the medical societies of Oregon, Washington, Arizona, Idaho, and California, who held a meeting in San Francisco on Tuesday and Wednesday, November 2 and 3, 1943, on call issued by the Committee on Maternal Welfare of the State of Washington. These resolutions appear on page 293.

PUBLIC RELATIONS SURVEY CONCERNING MEDICAL PRACTICE

A Misinformed Public.—At a meeting held on October 10, 1943, the Council of the California Medical Association took action on several matters of great importance to medical practice in California. The minutes appear in this issue and should be scanned or read by every member of the California Medical Association, since the decisions reached may have a direct influence on medical practice in this State at the present time and for the more remote future.

The unsettled conditions that are a part of the global war in which our country is now engaged have led not only to radical changes in industrial, agricultural, and economic relationships, but have also brought to the front a host of social welfare problems. Some of these latter welfare or human betterment proposals have serious implications for medical standards and practice. The proponents of such measures are more than active, not only in putting forth militant educational propaganda, but what is of more serious import, securing legislative enactments designed to lay the foundation for far-reaching plans that would radically change the practice of medicine. Once such a foothold is secured, through either state or federal enabling or other legislation, it is almost certain to follow that the officials concerned with the administration of the activities will seek to enlarge the scope of their jurisdictions and projects. It is well known that many of the plans on matters related to the problems concerned with adequate medical care have been under the sponsorship or supervision of lay persons or bureau chiefs, sometimes with, and at other times, without the advice of physicians who are in active practice.

The proponents of the "new order" put forward their propositions under a banner of idealistic altruism, thus making it doubly difficult for physicians to bring to citizens a proper understanding of the principles at stake. All kinds of smoke screens are used to becloud the issues and, as a result, many voters are persuaded to accept programs with which they would not be in sympathy had they previously been supplied with true information. Because of such propaganda, it is not surprising that the attitude of citizens to the medical profession has undergone a great change in the last ten years or so. If the reaction of coldness or antagonism to organized medicine is permitted to continue, it will not be long before scientific medicine and the quality of medical practice in general will be placed in real jeopardy. Such a result must not be permitted to come to pass. It is not yet too late to bring about a change of view.

* * *

Attention Is Directed to the Survey Now Under Way.—Members of the Association who make a point of keeping in touch with Council proceedings may have noticed Item 9 of the minutes of the meeting of August 22 (page 173 of CALIFORNIA AND WESTERN MEDICINE for August), in which reference was made to the plan submitted by Speaker Askey of Los Angeles, emphasizing the need of a survey that would give to the Association a more accurate picture of California public opinion, in so far as it relates to the medical profession.

In the current issue appears the report of the Special Committee then appointed (Item 5 on page 273). It will be noted that the Council of the Association deemed it to be expedient to authorize the making of a survey, the same to be started at an early date. The services of the well-known firm of Foote, Cone and Belding, successors to the nationally known Lord and Thomas group, have been engaged to do the work. Readers are requested to inform their colleagues of the above action, since it will be possible to carry on the work with better results if physicians generally know about the proposed survey. Doctors will then be in better position to register their approval should they be called on to express to patients or friends an opinion of the investigators operating for the California Institute of Public Opinion, that being the name under which the survey will be carried on. It is hoped to secure an accurate cross section of California public opinion representing all walks in life. With proper support by the physicians of the State, this should be possible. Next steps in procedure will then be in order.

"AGRICULTURAL WORKERS' HEALTH AND MEDICAL ASSOCIATION": ITS MEDICAL ACTIVITIES ENDANGERED

California Medical Association Has Coöperated With the Government.—When, several years ago, the problem of the migratory agricultural workers came to the front in California, the medical care needed by many of the migrants received considerable attention. CALIFORNIA AND WESTERN MEDICINE presented editorial and other comment on the subject. Many readers will remember that when the Council of the California Medical Association was asked for advice by the governmental authorities, the name of Dr. Karl L. Schaupp of San Francisco, present president of the California Medical Association, was submitted for election to the board of directors of the "Agricultural Workers' Health and Medical Association"—a nonprofit corporation under governmental sponsorship, that was created to provide ways and means for adequate medical care of the migratory agricultural workers and their families. It is pleasing to know that the program then established has been successfully administered. Much of the credit for the medical phases is due to the work of Doctor Schaupp, who has given serious thought and time to the enterprise.

* * *

But Now Another Governmental Bureau Steps In.—It would be reasonable to assume that when a governmental agency is doing a much needed and vitally important service in successful manner that its mechanisms of procedure will not be disturbed. But alas and alack, in the present case, another governmental bureau—in an endeavor to make itself bigger, or to show its power, or for obscure reasons of political or other nature that have not yet become fully manifest—has seen fit to break into the picture and secure congressional legislation which, if not amended, may go far in nullifying the good medical care that has been thus far secured for the migrant workers, whose services are much needed in the agricultural districts of the Pacific States.

The bureau to which reference is made is the United States Employment Service. While it may be desirable for that agency to have in its files the names of all migratory workers, and so on, it surely is not necessary for it to espouse legislation that will deny to all migratory workers and their families who, struggling to secure work, merely fail to register through a United States Employment agency. Such a course penalizes the migratory agricultural worker who, in the American way, seeks and obtains work on his own initiative. If regimentation is necessary—and it should not be needed here—why enact it through a system that is obnoxious to the American mode of living? And why should a governmental bureau be so inconsistent and hard-hearted that only those who are willing to secure positions through its offices shall be permitted to have the medical care that has been supplied by the Government in its efforts to keep the migrant workers and their families physically fit? (For Council minute, see Item 15 on page 277.)

Proposed Amendment and Replies from Congressmen.—On other pages in this issue (pages 287-289) appear a copy of the letter which was sent to our California Congressmen in which a proposed amendment to Public Law 45 is indicated, and also the replies of the California representatives in Washington. The items are worthy of perusal. As stated, October 18, in the letter which was sent to Congressmen:

> The present wording of the Act is so restrictive that it excludes from medical care all agricultural workers who do not receive their employment as a result of some activity of some of the Government agencies financed by Public Law 45. This means that our own American agricultural workers who have sufficient initiative and ingenuity to develop employment resources of their own are denied medical assistance.

Component county societies who do not find reply letters from their respective Congressmen in the list elsewhere printed should feel free to again call attention to the proposed amendment. A list of Congressmen with their district numbers is given on page 285. Let us not fail in this. Write to your Congressman and urge enactment of S. 1493 (see page 287).

PROBLEMS IN HOSPITAL NURSE ADMINISTRATION: ALSO A SAN FRANCISCO PROBLEM

Luxury Medicine.—"Luxury Medicine," one of the terms that war conditions have brought to the front, applies alike to certain medical service and nurse care, as given both in hospitals and homes. Under existing conditions, the reasons are understandable why unnecessary demands upon the time and services of physicians and nurses and the facilities of hospitals should not be made, when it is remembered that almost fifty thousand physicians, and more than thirty thousand graduate nurses, have been transferred from civilian into military practice. With such inroads upon physician and nurse personnel in civilian circles—at a time, too, when many communities have taken on increased activities in wartime industries—it should be evident to all that, if remaining physicians and nurses are to keep fit to carry on their work, especially with the extra duties thrust upon them, it will be necessary for all concerned to make sharp adjustments to have available services measure up to the standards laid down in recent years.

* * *

Some Causes of "High Costs of Medical Care."—In many places, the "high costs of medical care" has been partly the joint fault of physicians and patients, since doctors found that time was conserved when patients were given care under institutional conditions; the patients acquiescing to the proposal for such supervision in the belief that recovery, with good results, would also be greatly expedited. The shock came, as a rule, not because the above procedures failed to work out in practice, but because the extra expense involved in professional service rendered in a hospital—(in one sense, an institution providing hotel service only to sick and injured persons)—was over and above what many families were in position to pay without subjecting themselves to subsequent financial hardships and debt. It is possible, also, that one of the reasons why so many persons have today swung away from the medical profession is due in part not only to the larger amount of specialism that has become the vogue in modern medical care, and its increased expense, but also because, with these newer procedures, there has been lost, and many times, the human understanding, sympathy, and mutual esteem between physician and patient that were so prominent a feature in medical practice up to the last decade or so. Perhaps war conditions will aid in the reëstablishment of the much to be desired former physician-patient relationship.

* * *

Progress in the Nursing Profession.—Medical progress of late years has not been altogether dependent on the medical profession, since its handmaiden, the nursing profession, has been of great aid. The transition from practical to registered nursing, with constant improvement in the education and training provided by accredited schools, has been notable. Therefore, it is not surprising that, in recent years, duty assignments of nurses in many hospitals were changed from twelve to eight-hour shifts. Particularly has this been the case in regard to special nurses.

* * *

Government's War Needs in Nursing Service.—Comes now the war, with 32,000 graduate nurses already in service with the armed forces, and a quota of 32,000 additional nurses to be supplied during the coming year; that campaign being under the sponsorship of the American Red Cross. Nor is this all, for our Government has established the "United States Nurse Cadet Corps," and through the United States Public Health Service and associated groups, seeks to matriculate 62,000 high school graduates during the next twelve months, to receive training in accredited schools of nursing; the costs of tuition and maintenance of the student nurses to be paid by the Government.*

* * *

A San Francisco Hospital Problem.—On other pages of this issue are items telling of certain complications which have arisen in the administration of hospitals located in the San Francisco area. The Stanford Hospital, for example, found it necessary to outline a plan for a readjustment of special nursing. However, as submitted, the changes failed to secure the approval of organized nursing. A modified plan has since been submitted and is being tried out for a period of three months. Here again, medicine and its allied interests are faced with another problem in which the give-and-take elements must come into action if a happy solution is to be found. It is to be hoped that whatever is finally decided upon will work out to the best interests of all concerned, namely, to patients, hospitals, physicians, and nurses. Readers who are interested will find the various items referred to, on page 290.

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* For other information, see CALIFORNIA AND WESTERN MEDICINE, September, pages 188-189.

ENTEROHEPATIC CIRCULATION OF ESTROGENS

An interesting contribution to the physiology of sex hormones is contained in proof of an enterohepatic circulation of estrogens recently reported by Cantarow[1] and his associates of Jefferson Medical College, Philadelphia.

Data previously reported by these clinicians[2] led to the belief that considerable quantities of exogenous estrogen are excreted in the bile. To confirm this belief, bile was obtained by duodenal intubation of menopausal women before and after intramuscular injection of 120,000 I. U. diethylstilbestrol. The initial samples were negative. During the first half-hour after injection, however, 440 I. U. were recovered from the bile, increasing to 8,200 I. U. during the fourth half-hour period, and then decreasing to 108 I. U. during the seventh half-hour period. The total biliary excretion during the first three and one-half hour period was 15,558 I. U., or 13 per cent of the intramuscularly injected dose.

In order to confirm the postulated excretion for endogenous estrogens, bile was obtained by the same technique from several women at full-term pregnancy, and three to seven days after delivery. An average of about 800 I. U. estrogen per 100 c.c. was demonstrated in full-term pregnancy bile, contrasted with 250 I. U. in the blood stream. The biliary excretion fell to 240 I. U. by the seventh postpartum day, at which time the blood assay showed only 9 I. U.

Similar tests were made on bile-fistula dogs. After intravenous injection of 4,000 units of chorionic gonadotropin or pregnant mare serum gonadotropin, bile was collected for four consecutive twenty-four-hour periods. These samples showed an average total biliary excretion of 600 I. U. by the end of the fourth day, or approximately 15 per cent of the intravenously injected dose.

In order to determine the subsequent history of this excreted estrogen, 300,000 I. U. (3 mg.) alpha-estradiol in 5 c.c. bile were introduced into an isolated canine jejunal loop. Some forty-five minutes later blood was allowed to flow for a half-hour period from the severed veins, draining this loop. Analysis showed 6,000 I. U. estrogen per 100 c.c. in this drainage blood.

From these and other data, Cantarow concludes that large amounts of both endogenous and exogenous estrogen are excreted in the bile in which it may be present in much higher concentrations than in the peripheral blood or urine. The rapid absorption of estrogen from the isolated intestinal loop points to a very efficient enterohepatic circulation of both exogenous and endogenous estrogen, which may prove to be of practical clinical interest.

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1. Cantarow, A., Rakoff, A. E., Paschkis, K. E., Hansen, L. P., and Walkling, A. A.: Proc. Soc. Exp. Biol. and Med., 52:256 (March), 1943.

2. Cantarow, A., Rakoff, A. E., Paschkis, K. E., and Hansen, L. P.: Proc. Soc. Exp. Biol. and Med., 49:707, 1942.

ORIGINAL ARTICLES

Scientific and General

VOLUNTARY HEALTH PLANS IN CALIFORNIA*

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THE Executive Committee of the California Medical Association at its 180th meeting held in San Francisco on Sunday, February 7, discussed California Physicians' Service and the Hospital Service Plans in California, and voted to make a survey of existing conditions as regards medical and hospital service plans in California. It was voted also that the scope of the survey should be confined to the respective activities of medical and hospital service plans, and how the same may be promoted to the best advantage of the organizations involved and public welfare. The writer was retained to conduct the survey, and this is his report to you.

During the course of the survey, conferences were held with members of the Board of Directors of the California Physicians' Service, Hospital Service of California, Hospital Service of Southern California, and the Inter-Coast Hospitalization Insurance Association. Conferences were also held with officers and members of the Council of the California Medical Association, the Association of California Hospitals, and with a Hospital Service Plan Committee of the latter association. There were also interviews with attorneys for California Medical Association, California Physicians' Service, Association of California Hospitals, and Hospital Service of Southern California. (The attorney for the Inter-Coast Hospitalization Insurance Association was present at a meeting held with the Board of Trustees of that association, and the attorney for Hospital Service of California was present at a general meeting of interested persons held in San Francisco.) There were also interviews with executives of California Physicians' Service and executives of the three hospital service plans, as well as with various practitioners of medicine and hospital executives and trustees throughout the state. During the course of these various contacts, it became evident that progress of voluntary health plans in California was dependent primarily upon proper organization of these plans and coördination of their activities. For this reason the survey was confined principally to consideration of changes in organization which will tend to increase the effectiveness of these organizations, to accelerate their development and to increase their usefulness.

Purpose of Voluntary Health Plans

Any study of voluntary nonprofit health plans should keep in mind the three primary objectives of these plans, which may be stated as follows:

1. To assure the people adequate medical and hospital care without financial hardship. Voluntary health plans give this assurance by making it possible for the individual or family to budget for the cost of medical and hospital care by making regular payments.

2. To assure the medical profession and hospitals adequate fees for their services and to stabilize the income of both the profession and hospitals. Voluntary plans make this possible by collecting small sums of money from great numbers of people each month, which are redistributed to hospitals and the medical profession in accordance with services rendered by them to such persons. It is obvious that more adequate payments can be made for medical and hospital care if the individual and family have a method whereby they can pay for such care on a periodic basis rather than having to meet the entire cost of such care at the time of illness. This tends also to give the physician and hospital a regular and assured monthly income.

3. To preserve a private practice of medicine and the voluntary hospital system without interference by government, without compulsion, and without taxation. Unless the medical profession and hospitals can make adequate care available through voluntary prepayment health plans, there will be a public demand that government provide health services. As a matter of fact, such a demand on the part of the people already exists. It is, however, not too late for the profession and hospitals to meet the public demand in a voluntary nonprofit way.

Principles of Voluntary Health Plans

The American Hospital Association endorsed principles for the prepayment of hospital service in 1933, and established a list of essentials or principles which should characterize such plans. In 1937 the trustees of the American Hospital Association authorized the approval of hospital service plans meeting these essentials or principles. The House of Delegates of the American Medical Association at its meeting in 1937 adopted principles which were considered necessary to safeguard quality of medical service under hospital plans. The principles adopted by both associations are similar, and it is felt that they apply equally to the medical plans as well as to hospital plans, and are, therefore, summarized here. Any evaluation of health plans should be on the basis of these principles. They include:

1. Emphasis should be placed on the public welfare by such plans. The American Medical Association points out that hospital plans should not be utilized primarily as a means to increase hospital occupancy, nor should they place emphasis on hospital finances.

2. There should be adequate representation of the medical profession, hospitals, and the general

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* This survey was made by Mr. John R. Mannix, director of Michigan Hospital Service.

For references to minutes of California Medical Association Council, granting authorization for the survey, see in CALIFORNIA AND WESTERN MEDICINE as follows: March, 1943, Item 12, on page 131; April, 1943, Item 10, on page 239; July, 1943, Item 10, on page 75; September, 1943, Item 8, on page 172.

public. The principles provide also that the trustees or board members of the plans should receive no remuneration for service as trustees or board members.

3. There should be nonprofit sponsorship and control. There should be no diversion of funds to individuals or corporations seeking to secure subscribers for profit. No organizations or individuals advancing the initial capital should attempt to influence or direct the management of plans because of their financial support.

4. There should be free choice of hospital and physician. The plan should include all reputable hospitals.

5. The medical profession and hospitals should accept responsibility for service to subscribers. The American Hospital Association states: "The ultimate economic responsibility for service to subscribers enrolled at any given time should be assumed by member hospitals through definite contractual agreements with the hospital service plan." In the case of the medical plan, the medical profession should likewise accept the "ultimate economic responsibility for service."

6. There should be efficient management, adequate accounting and statistical records. There should also be adequate spread of risk, and each plan should serve the largest possible geographic area that legal restrictions and economic conditions permit.

7. There should be equitable payments to the medical profession and hospitals. The American Hospital Association's principles provide that "Payment to hospitals should be based on cost of services provided to the subscribers in hospitals of that community, district or region." Payments to physicians should likewise be in accordance with income which they would receive in the area for similar services.

8. There should be dignified promotion and administration. Employees should be reimbursed by salary as opposed to a commission basis. There should be no commercial or high-pressure salesmanship or exorbitant or misleading advertising to secure subscribers. Such tactics are contrary to medical and hospital ethics and sound public policy.

9. Subscribers' benefits should be based on local professional and hospital practice. The American Hospital Association's principles provide that hospital service provided through a hospital service plan should be determined by the practices of member hospitals of the particular plan. The House of Delegates of the American Medical Association at its meeting in San Francisco in 1938 stated: "If for any reason it is found desirable or necessary to include special medical services such as anesthesia, radiology, pathology or medical services provided by out-patient departments, these services may be included only on the condition that specific cash payments be made by the hospitalization organization directly to subscribers for the cost of the services." (Where medical and hospital service plans are operated in coöperation with each other, as this report recommends should be the case in California, this is easily solved.)

10. There should be no interference with professional relationships. Health plans should not interfere with existing relationships between physicians and hospitals or between physicians and patients.

11. There should be an upper income for subscribers. The principles of the American Medical Association make the foregoing provision. However, it is the present thinking among the majority of people in the medical and hospital fields that while an income limit is desirable in the case of medical service plans, it is not necessary in the case of hospital service plans. The reason for this difference is that it has been traditionally the practice of the medical profession to base their fees on the ability of the patient to pay. This practice, however, has not been followed by hospitals. Different hospital rates are set for given accommodations and generally such accommodations are available to everyone irrespective of their financial resources. In other words, the wealthy man may choose the lowest-priced accommodation and a person with more limited resources may choose the most expensive private room. If, however, a low-cost hospital plan for persons unable to meet the full cost of hospital care is ever developed, then there should be an income limit in such a plan.

12. Health service plans should conform to state statutes and case law.

History and Progress in the Nation

Medical service plans under the sponsorship of medical associations had their origin in 1930, when various county medical societies throughout the states of Washington and Oregon offered medical service on a prepayment basis to people in those states. However, the medical service plan movement did not show much progress until the establishment of California Physicians' Service in 1939. This organization is the first state-wide medical plan under the sponsorship and control of the medical profession. During the four years since the organization of the California Physicians' Service, seven state medical societies have organized similar plans. These are the societies of Massachusetts, New Jersey, Pennsylvania, Delaware, North Carolina, Michigan and Colorado, and the Oregon Medical Association has recently merged the original County Medical Plans formed in that state into a state-wide plan known as Oregon Physicians' Service, so that there are nine state-wide medical plans at the present time. In addition to state-wide medical plans, plans under sponsorship of local medical associations are now in operation in New York State, Texas and Washington, and the medical professions in at least five other states are giving serious consideration to the development of medical plans. These states include West Virginia, Georgia, Ohio, Wisconsin, and Utah. Exact figures on medical service plan enrollment are not available. However, as of March 1, 1943, California Physicians' Service had enrolled approximately 88,000 subscribers; Michigan Medical Service had enrolled approximately 440,000 subscribers. Enrollment in Washington and Oregon exceeds 200,000 subscribers, and the total enrollment in the twelve states having medical plans is over 800,000 subscribers.

Throughout the nineteenth century and during the early part of the twentieth century, there were many hospital service plans operated by individual hospitals, but it was not until 1932 that a plan was organized offering free choice of hospital. This plan was started at Sacramento, California, in July, 1932. The formation of this plan may well be said to be the start of the present development of voluntary nonprofit hospital plans offering free choice of hospital. During 1933 and 1934, other free choice hospital plans were organized at Newark, New Jersey; St. Paul, Minnesota; Durham, North Carolina; New Orleans, Louisiana; Washington, D. C.; and Cleveland, Ohio. By 1935 twelve hospital service plans had enrolled 97,000 subscribers. By January, 1940, sixty plans had enrolled 4,500,000 subscribers. On April 1, 1943, seventy-seven plans had enrolled over 11,000,000 subscribers. These plans are operating in thirty-five states, the District of Columbia, and three provinces in Canada. These seventy-seven plans bear the Blue Cross stamp of approval of the American Hospital Association, having met the approval standards outlined previously in this report. The thirty-five states and the District of Columbia where Blue Cross Plans are operating contain approximately 90 per cent of the population of the United States and the three provinces contain approximately 40 per cent of the population of the Dominion of Canada. Of the thirteen states without Blue Cross Plans, four already have special enabling acts, and efforts are being made by the Hospital Service Plan Commission of the American Hospital Association to establish plans in all thirteen states at a very early date.

There has been a truly spectacular development of nonprofit health plans during the past eleven years. There were many enthusiastic persons who attended the first conferences on group health care during 1933 and 1934, but few of them visualized the coming growth and future magnitude of this movement. Despite the development which has taken place, there are many friends of this movement who honestly believe, and many opponents who contend, that these plans have reached their full development and cannot be expected to reach a much larger portion of the people. However, it is our prediction that with the support of the medical and allied professions, and with the support of hospital trustees and executives, all the people of this country will be relieved of the financial burden of health care within a reasonably few years through medical plans and companion Blue Cross hospital plans.

Progress of California Physicians' Service

California has the honor of being a pioneer in the health service plan movement. As previously stated, the first free choice hospital service plan was organized at Sacramento in 1932, and the first state-wide medical plan was organized in California in 1939. Much of the credit for the present nationwide development of health plans must be given to California. However, while California has been a pioneer in both the hospital and medical service plan fields, nevertheless, many other areas of the country have enjoyed greater success.

Consider first the growth of California Physicians' Service. After four years of operation this plan has enrolled 88,000 subscribers, or approximately 1.2 per cent of the population, whereas Michigan Medical Service, which was started a year later, has enrolled 440,000 subscribers, or 8 per cent of its population. At the present rate of growth, it would take over 300 years to enroll all Californians in California Physicians' Service.

There appear to be several reasons for slow progress in California. These include:

1. The feeling upon the part of some physicians that California Physicians' Service was established for the sole purpose of forestalling state medicine. While this may well be one of the results, physicians must appreciate that such plans are necessary to assure the public of adequate medical care without financial hardship, and at the same time to assure the physician a fair fee for all his services.

2. Failure on the part of the plan to capitalize on early public interest in the program. This enabled commercial insurance companies, group clinics, and industrial plans to prosper and enjoy rapid growth while California Physicians' Service was being organized and starting operation.

3. Tendency to place emphasis on development of medical service through government agencies, namely, through Farm Security Administration and Federal Housing Authority rather than through regular industrial and business groups. Over 50 per cent of the present enrollment of California Physicians' Service covers persons who are Farm Security Administration clients or persons who occupy Federal Housing Authority homes.

4. Tendency to offer an ideal medical service contract providing complete medical service rather than offering a contract for partial or limited medical care, which could be offered at a relatively low rate, and which probably would be of interest to much greater numbers of persons at the present time.

It is believed that a great part of the success of voluntary health plans is due to the fact that eleven years ago, hospital service was offered to the employed individual only for rates as low as $.02 a day, or $.60 a month. It was because of the smallness of this charge that hundreds of thousands of people availed themselves of this service. After four or five years' experience with such a contract, there developed a great demand for hospital service for the entire family. This was then offered at rates as low as $.05 a day or $1.50 a month. This time millions of persons throughout the country availed themselves of this protection. In 1939 and 1940 California Physicians' Service, Michigan Medical Service, and Western New York Medical Service offered hospital and medical care to the individual at rates of approximately $2.50 per month. The Michigan and Western New York plans also offered hospital and medical service to the entire family at rates of approximately $6 per month. In none of these instances were the medical plans successful, and it is believed that the reason for the lack of success was the fact that individuals who were paying $.60 to $.80 a month for hospital service were not yet ready to pay approximately $2.50 a month for complete medical care, and families who had been paying approximately $2 a month for hospital service were not yet ready to pay approximately $6 a month for complete medical care. In light of these experiences, it appears wise to offer only partial medical protection at this time, and the greatest demand appears to be for contracts offering hospital and surgical service.

5. Another factor affecting development in California is the complicated rate structure. Subscriber rates have been changed from time to time, and different rates are quoted for large groups and small groups, for males and females, for families with one child, and families with a greater number of children. This complicated rate structure makes it very difficult for representatives in presenting the plan to employers and prospective subscribers. The rate structure can be greatly simplified and still result in the same income per person protected. When this is done, a much more effective presentation of the plan can be made.

6. Another factor retarding progress is the difference in benefits and difference in restrictions and limitations between hospital service plan contracts and the medical contracts. It is believed that the surgical service contract should include obstetrical care not only in the case of ectopic pregnancies and cesarean operations, but also in case of normal deliveries. In other respects, benefits, limitations and enrollment regulations of the medical plan and the hospital plan should be similar.

7. One of the principal obstacles to the development of California Physicians' Service has been the fact that the unit value of physicians' services has been such a low point. This has resulted in lack of support on the part of many physicians, which in turn affects the public confidence in the plan and prevents progress. Every effort should be made to increase the value of the unit. It is believed that this can best be done by placing emphasis on a surgical service contract, and offering a medical service contract with the two-visit deductible feature only in those instances where there is insistence upon this type of contract. It is further believed that the surgical service contract can be offered at a rate that will permit payment to the doctor of a full-fee schedule or full unit value.

8. California Physicians' Service has not had the full and wholehearted support of a substantial majority of the physicians in the state and in several counties has had little or no support. In a sense the plan cannot be considered a truly state-wide plan. The plan must have the support of the great majority of the physicians, if not all physicians, before real success can be expected. Physicians should accept the responsibility to render service to subscribers under the plan, and it is believed that the agreement with physicians should provide that they will furnish service for a twelve-month period, and that cancellation of their membership is only effective under twelve months' written notice. The average person cannot be expected to enroll in the plan unless there is some assurance that participating physicians will continue to render service for a reasonable period of time.

9. Another factor which has hindered the development of the medical plan has been the lack of complete coöperation with the hospital plans, and coördination of these plans with the medical plan. At the present time there are really four hospital plans in the state, one being offered by California Physicians' Service, and the others being offered by the Hospital Service of California, Hospital Service of Southern California, and Inter-Coast Hospitalization Insurance Association. There are three medical plans, one offered by California Physicians' Service, one offered by Hospital Service of California, and one offered by Inter-Coast Hospitalization Insurance Association. The offering of four hospital plans and three medical plans in the state is ample evidence to the public of the lack of coöperation within the medical group and within the hospital group, as well as between the medical profession and hospitals. Until this situation is corrected, much progress cannot be expected. There must be coördination of medical and hospital plans as regards rates, benefits, contract limitations, enrollment regulations, office procedure, as well as general policy.

Progress of California Hospital Plans

There are three hospital service corporations in California. The Sacramento Plan has been operating since 1932, the Oakland Plan since 1937, and the Los Angeles Plan since 1938. As of January 1, 1943, these three plans had enrolled 127,812 people. This is 1.8 per cent of the population. At the present rate of growth, it will take 300 years to enroll all of the people in California. It is interesting to compare the percentage of enrollment in California with the percentage of enrollment in the ten most populous states. This enrollment follows:

	Per Cent
New York	15.7
Pennsylvania	11.4
Illinois	8.0
Ohio	20.9
California	1.8
Texas	1.0
Michigan	16.1
Massachusetts	10.6
New Jersey	10.0
Missouri	9.9

It will be noted that eight of the ten most populous states in the Union have enrolled 8 or more per cent of their population in approved Blue Cross Plans. This again compares with California's 1.8 per cent. Only Texas, which has a relatively new plan, shows a lower enrollment.

It is also interesting to compare California's enrollment of 1.8 per cent with that in states having state-wide plans. Enrollment in some of the state-wide plans is as follows:

	Per Cent
Alabama	3.2
Maine	6.3
Maryland	8.8
Massachusetts	10.6
Michigan	16.1
Minnesota	18.5
New Jersey	10.0
Rhode Island	16.6
Colorado	15.1
Delaware	22.5
North Dakota	4.3

The above figures would seem to indicate that much more rapid acceptance of prepayment hospital service might be expected if there were a single state-wide plan in California.

Until 1932 when the Sacramento Plan was organized, all hospital service plans were operated by individual hospitals. From 1932 until 1938 we witnessed the development of community-wide hospital service plans. Since 1938 the tendency has been to develop hospital service plans on a state-wide basis. There are now plans in thirty-five states, the District of Columbia, and three provinces of Canada. Twenty plans are state-wide, one serves the District of Columbia, and three plans are province-wide. On the other hand, fifteen states, of which California is one, have a total of fifty-two plans, operated on a community or local area basis. Some of the early community plans are now state-wide; this is true in the case of the Newark plan, which now serves the State of New Jersey, and the St. Paul plan, which serves the State of Minnesota. State-wide plans are being considered in New York, Ohio, Illinois, Kentucky, North Carolina, and Louisiana. At the present time these particular states have from two to nine plans each. There are a number of advantages to the development of hospital (as well as medical) service plans on a state-wide basis. These advantages are:

1. From the standpoint of the subscriber, there is a much greater choice of hospital, and therefore the plan is more appealing to him. There is still a great deal of travel even during the war period, and the subscriber realizes the advantage of having the privilege to go to any hospital in the entire state in case of emergency, securing care on a service basis, rather than having service limited to hospitals in his community.

2. From the standpoint of the employer, particularly the state-wide employer, there is the advantage that he has only one plant rather than several with which to deal. This simplifies his problem in offering hospital care to his employees, not only from the standpoint of the presentation of the plan, but also from the standpoint of office details in connection with pay-roll deduction and other matters.

3. From the standpoint of the hospital, there is but one plan to deal with rather than several. This tends to simplify the hospital problem, particularly from an admitting office and accounting standpoint. At the present time there are no two hospital service plans in the country with the same admission forms and regulations, or the same billing forms or regulations. This situation greatly adds to the clerical problem of the hospital.

4. From the standpoint of the hospital service plan, there are several advantages in a state-wide plan. Inasmuch as free choice of hospitals throughout the state is offered, the contract is much more attractive and individuals in a group are more likely to be interested in the service.

State-wide or national employers are much more likely to coöperate with a single state-wide plan than they are with a group of local plans. This also increases enrollment.

Perhaps the most important advantage is that in a state-wide plan there is a much greater spread of risk. This leads to greater financial soundness, inasmuch as state-wide plans would not be affected by local fluctuations in the incidence of hospital care to the same degree that local plans would be affected by such fluctuations.

There are a number of conditions hindering state-wide development. These conditions include:

1. The matter of local pride. The trustees and executives of local hospital plans as well as the trustees and executives of local hospitals are generally very proud of their accomplishments. They hesitate to merge their interest with those of adjoining communities. However, it is believed that all groups can render a much more valuable public service by extending their interest to a state-wide basis rather than confining it to a local community.

2. There is also the question of relative reserves built up by various community plans. Plans having built up large reserves hesitate to merge with those having smaller reserves. However, it is believed that this problem is easily solved by first determining the minimum amount of reserve on a subscriber basis held by each plan, and having each plan contribute the amount of this minimum to a common reserve fund in the new state-wide corporation. Any excess reserve over and above this minimum held by a particular plan could be held by the new corporation for the special protection of the hospitals and subscribers in the area where their reserve was created for a period of three to five years, after which time any balance of the special reserve which remained could be transferred to the common reserve fund.

3. Another difficulty delaying forming of state-wide plans is the fact that hospital costs and charges differ throughout the state. However, this problem has been solved satisfactorily in the twenty-four states or provinces having state-wide or province-wide plans, and can be solved in California by fair consideration of all the factors involved.

4. A fourth situation hindering state-wide development is the feeling that "this state is different." In California, for instance, there is a feeling that because of certain differences between Northern and Southern California, and the size of the state from both an area and population basis, it might be advisable to have a Northern California Plan and a Southern California Plan. However,

the territorial differences that exist in California are no different from those which exist in states like Massachusetts, New Jersey, Minnesota, Michigan, and Colorado, which have successful state-wide plans. State-wide plans have been successful in states like Michigan, Massachusetts, New Jersey, whose total population is close to that of California. They have been successful in states like Minnesota, Michigan, and Colorado, which cover very large areas.

There are many important reasons for state-wide development of hospital service plans, and no valid objections. It is felt that the development of a single state-wide hospital service plan in California is of primary importance in the future of the hospital service plan movement, not only in this state, but throughout the nation.

Federal Government Proposals

Since the development of compulsory health insurance in Germany in 1880, there have been numerous legislative attempts to introduce compulsory health insurance in various states of the Union, as well as on a national basis. These attempts are largely the result of public pressure which results from the fact that relatively few people can meet the cost of medical and hospital care at the time of illness, and inasmuch as this problem has not been successfully met on a large scale by the medical profession and voluntary hospitals we get pressure on government. While this pressure has not been well organized, there can be little doubt that there is great public interest in such proposals. This was evidenced late in 1942 when a poll by *Fortune Magazine* showed that 74 per cent of the population of the United States was in favor of some form of government health insurance. In January, 1942, President Roosevelt, in his budget message to Congress, recommended that the Social Security Law be amended to provide for hospitalization benefits. Legislation covering the President's recommendation was later introduced in Congress. This legislation was known as the Elliott Bill. This bill was not successful, but similar legislation, known as the Greene Bill, has been introduced in the 1943 session of Congress. No reasonable person objects to the Federal Government entering any necessary activity where private enterprise and individual initiative have failed, but we do not believe that any person who feels that individual initiative and private enterprise are important to the American way of life will agree that the Federal Government should enter into any activity where great progress is being made through the conscientious efforts of private agencies. We feel, therefore, that it is important that the medical profession and voluntary hospitals develop successful voluntary health plans on a nonprofit basis. These plans must be so developed that we will reach millions of Americans through them. It is not enough that 800,000 persons now have voluntary medical plans, or that 11,000,000 persons are protected by voluntary hospital plans. We must think in terms of medical and hospital coverage through voluntary nonprofit agencies for at least 50,000,000 persons within the next decade if the American public is going to approve voluntary plans, and if the demand for compulsory health insurance is to be dropped.

Voluntary hospital service plans known as contributory schemes have been very successful in England, and it is interesting that Sir William Beveridge, in his Report on Social Insurance and Allied Services in England, in which he proposed various forms of security "from the cradle to the grave," including national medical service, makes special exception in the case of hospital contributory schemes. He states: "The growth of hospital contributory schemes in the years just before this war has been remarkable. They are stated to cover more than 10,000,000 wage-earners, and they produce more than 6,500,000 pounds a year for the voluntary hospitals; the cost of collecting this money is put at about 6 per cent; in London and some other parts of the country, contribution to a hospital saving association qualifies the contributor for free treatment either in a voluntary hospital or in a public hospital as may best suit his case. . . . Should a payment for this purpose be included in the compulsory insurance contribution, and be passed on as a grant from the social insurance fund to the health departments toward the maintenance of the institutions? The answer to this financial question, like the answer to the other similar question, as to domiciliary treatment, involves problems of organization as well as finance. If payment for institutional treatment is included in the compulsory insurance contribution, there will be little or nothing left for which people can be asked to contribute voluntarily, and an important financial resource of the voluntary hospitals will come to an end. It will then be for the health departments to use the grant that they will receive from the social insurance fund in whatever way best fits their hospital policy. If it is not included, people of limited means will have the choice, as at present, of contributing voluntarily beforehand, or paying at the time of treatment, as best suits their means."

This statement would indicate that while Sir William Beveridge believes that Government protection from the "cradle to the grave" should be provided for every individual, on the other hand he believes that the hospital contributory schemes which are one of the most successful forms of protection now available to the English people, should not be disturbed. It is reasonable to believe that if the medical profession and the voluntary hospitals of the United States make voluntary health plans available to the great mass of American people on a nonprofit basis, we will have little to fear in the way of compulsory health insurance in this country.

Recommendations

A study of the history and development and present status of medical and hospital service plans in California has resulted in a number of conclusions which are set forth in the following recommendations:

1. There should be developed a new nonprofit corporation for the purpose of operating a state-

wide hospital service plan. This corporation should be organized under the nonprofit hospital service plan section of the Insurance Code of California. It should be developed in accordance with the approved standards adopted by the American Hospital Association and the American Medical Association. It should, upon approval of the hospitals of the state and the three present hospital service plans, takeover the operation of the three plans, as well as their assets and liabilities; the reserves of the three plans to be handled in the manner described elsewhere in this report.

2. The activities of the new state-wide hospital plan should be coördinated with those of California Physicians' Service. There is need for coördination at three levels: first, the trustee level; second, executive committee level; and third, executive level. It is recommended that coördination at the trustee level be obtained by election to the medical plan board by participating hospitals in the state-wide plan of a number of trustees to be later agreed upon, and, further, that there be elected by participating physicians, by their duly constituted representatives in California Physicians' Service, an equivalent number of physicians in active practice to serve on the hospital plan board. It is believed that the interlocking of the board of California Physicians' Service and the Hospital Plan board will prevent misunderstandings and conflicting actions which might occur if individual actions on similar matters taken by two entirely different boards, meeting at different times and at different places and acting on similar matters.

It is proposed that there be an executive committee made up of an equal number of representatives from California Physicians' Service who shall be physicians in active practice and the Hospital Service Plan board; this executive committee to be responsible for the operation of both corporations.

It is further proposed that the executive committee employ an executive who will be in charge of the actual day-to-day operation of the affairs of both corporations. This executive would be responsible to the executive committee, and have charge of all employees necessary in operating the medical and hospital plan. This executive should be an individual who would have the confidence of the medical profession and hospital executives, who has an understanding and sympathetic interest in private practice of medicine and the voluntary hospital system. He should have had experience in the medical and hospital service plan field, or in allied fields which would qualify him for this position. He should have proved executive ability as well as the ability to contact the large employers of the state and to receive a sympathetic audience from them.

3. It is also recommended that there be a merger of the operating organizations of California Physicians' Service, Hospital Service of California, Hospital Service of Southern California, and the Inter-Coast Hospitalization Insurance Association. There should be a complete merger of all such activities as promotion, acquisition, enrollment, contract issuance, record keeping, billing and collection, and payment for service. There should be established a department of physician relations, the duty of which should be to keep the medical profession informed at all times of the progress of the organization and other matters of concern to the physician. There should also be developed a corresponding department of hospital relations, the duty of which shall be to keep hospital trustees and executives informed at all times of the progress of the Association and other matters affecting them.

4. It is proposed that there be developed by California Physicians' Service a separate subscribers' contract covering x-ray, medical anesthesia and pathological laboratory services. Income accruing from this contract would go to California Physicians' Service, which would, in turn, make all payments for these services. This would permit the offering to the public of a contract for hospital service, as well as an additional contract for certain medical services.

5. It is proposed that there should be a detailed actuarial study of the medical service plan and the limited surgical contract with the thought of offering services as comprehensive as possible at a subscribers' rate which will be attractive and which at the same time will assure the profession an adequate fee for its services. It appears wise to offer only partial medical protection at this time, and the greatest demand appears to be for a contract offering surgical service only. Such a contract is now being offered in California, Michigan and the western New York plans, which have had more experience than any other groups in writing medical services on a prepayment basis. Similar contracts are being offered also by all of the other medical service plans in the East. It is believed that only as the public has experience with the surgical service contract which can be offered at a relatively low rate, will they become interested in availing themselves in great numbers of more complete medical care at the higher rate which must be charged. As stated elsewhere, it is believed that a surgical service contract can be offered at a rate which will be acceptable to hundreds of thousands of people, and which rate, at the same time, will be sufficient to make payment to the physicians of an adequate and fair fee.

6. It is further recommended that the state-wide hospital plan adopt a comprehensive contract without restrictions and limitations (as recommended by the Hospital Service Plan Commission of the American Hospital Association, keeping in mind recommendation No. 4, above). Actuarial studies should be made to determine the subscribers' rate which will be necessary to make payment to hospitals at a fair and reasonable rate for their services. In this connection, it is recommended that a committee representing the hospitals of the state be asked to study hospital costs and charges for the purpose of developing a rate structure which will be fair to all institutions.

7. It is recommended that California Physicians' Service and the new Hospital Plan be developed in such a fashion so as to be in a position to serve the

adjoining states of Arizona and Nevada. Arizona has a population of approximately 500,000 persons, and Nevada a population of 110,000 persons. These states are hardly large enough to support successful medical and hospital plans. If the people of these states are to secure medical and hospital service on a voluntary prepayment basis, they probably will have to be served by the medical and hospital plans which also serve the State of California. The Inter-Coast Hospitalization Insurance Association is now serving Nevada, but it is felt that Arizona should also be served by the hospital and medical plans in this area.

8. It is recommended that every member of the medical profession in California (as well as Arizona and Nevada) should enter into an agreement to render service under the California Physicians' Service plan for a period of one year. It is likewise recommended that all general hospitals of these states registered by the American Medical Association enter into a contract to furnish hospital service for a one-year period. These contracts should be clear as regards the ultimate economic responsibility of the medical profession on one hand and the hospitals on the other to render medical and hospital service as provided for in the subscribers' contract. Without the acceptance of this responsibility upon the part of the medical profession and hospitals, and without the complete and enthusiastic support of both groups, nonprofit health plans can never be successful.

9. It is recommended that the public be represented in the operation of the medical and hospital plans. It is proposed that this be done in two ways: first, by the appointment of three advisory committees of five members, each representing the business fraternity, the labor group, and the agricultural group. Matters of interest to them should be discussed with them from time to time, and their advice should be presented to the Board of Trustees of both the plans for consideration and action. It is further proposed that there be established a sponsoring committee in each area of the state where branch offices are established. These sponsoring committees should consist of from six to as many as twenty-five of the citizens of the area representing the various groups of the area. Problems of interest to them should be presented to these sponsoring committees from time to time, and their advice should be referred to the two Boards for their consideration and action. It is recommended that there be at least quarterly meetings of the advisory committees, and at least semi-annual meetings of the sponsoring committees.

10. It is recommended that there be employed a public education director. This individual should have had experience in newspaper or related fields. It should be his duty to develop direct mail, newspaper and magazine releases, and other material which would keep the employers and public throughout the state informed regarding the medical and hospital plans. The four plans of the state have been weak in the matter of proper public education and public relations. Medical and hospital plans cannot be successful unless the public understands what they are attempting to accomplish and what they have to offer.

* * *

It is suggested that if this report and its recommendations are acceptable to the Council that copies be forwarded to the proper officials of the California Physicians' Service and the three Hospital Plans, and it is further suggested that, in order to carry out the recommendations of this report, the California Medical Association and the Association of California Hospitals both appoint committees of not more than five members, whose duty it would be to take such steps as may be necessary to put these recommendations in effect. The California Medical Association committee would deal with matters affecting medical practice and California Physicians' Service. The Association of California Hospitals committee would deal with matters affecting hospital service and the three hospital plans. In matters concerning both medical and hospital practice, or the medical and hospital plans, the two committees would serve as a joint committee.

California is the fourth largest state in the Union in population, and unquestionably one of the most important. The future of the private practice of medicine and the voluntary hospital system may well depend on the success or failure of voluntary health plans in this state. California is in a position to make an outstanding contribution to the voluntary health plan movement, and to the preservation of private practice of medicine and the voluntary hospital system.

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Respectfully submitted,
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TREATMENT OF BIRTHMARKS*

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MOST vascular birthmarks can be decreased markedly in size or even eradicated by a number of different methods. Since many of these disfiguring lesions occur in conspicuous places, the method of treatment selected should be one which substitutes for the hemangioma either normal skin or a scar which resembles it as closely as possible. Most of the unsatisfactory results of treatment can be attributed to the selection of the therapeutic agent without regard to its appropriateness for the character or type of hemangioma which is to be treated.

INCIDENCE

Vascular birthmarks are relatively common. Although some authorities believe that as much as one-third of all infants show such marks at birth, it is our impression that only one-tenth or one-twelfth of all infants show such lesions.

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The location is of even more importance. Watson and McCarthy[1] call attention to the fact that, although the head and neck make up less than one-seventh of the body surface, more than half in their large series of cases were found to be in these conspicuous locations. Peculiar, also, is the fact to which most authors agree, that the males outnumber the females in ratio of two to one, or even three to one. The former ratio is in accord with our experience of 92 cases treated in the last six years of private practice.

CLASSIFICATION

There are three types of vascular birthmarks, all of which may be present in the same tumor. Since the method of treatment which is selected depends not only on the size, shape, location, and growth characteristics of the tumor, but also upon the histological structure, classification is of major importance.

1. The "capillary hemangioma," or "port-wine stain," sometimes referred to as a hemangioma simplex, consists of a number of increased venules and capillaries in the deeper layers of the skin over which the epidermis is thin and velvety. All pediatricians are familiar with the simplest form of hemangioma simplex, which takes the shape of irregular patches of redness in the region of the eyelids, nose, forehead or in the nuchal region in the newborn. These red blotches almost invariably disappear six or eight months after birth. They are for this reason unique, for, although spontaneous regression may occasionally occur in other forms of hemangoima, it is rare.

In the more complex form, the capillary hemangioma is constituted by the familiar fiery red or purplish port-wine stain usually found on the head or neck, which is frequently in the distribution of the trigeminal nerve. The fact that the vessels lining these capillary hemangiomata have a well-differentiated lining of the adult variety, is of considerable importance from a therapeutic standpoint, for it explains the resistance to radium and other forms of therapy.

Unsatisfactory results in the treatment of capillary hemangiomata may be expected from radium or x-ray, for the advanced differentiation of the blood vessel endothelium in these lesions in adults is unlike the other forms of hemangiomata in which less endothelial differentiation is present. Unusually heavy doses of x-ray or radium are required to effect destruction of the well-differentiated lining in these blood vessels. Such heavy dosage, or even prolonged treatment with carbon dioxide snow, may cause the port-wine stain to become irregularly faded or pigmented. The final result is usually a geographical appearance which is considerably more disfiguring than the original lesion. With x-ray or radium the same danger is present as in the use of these agents for removing superfluous hair. To be effective, the dose must be sufficiently large to produce skin atrophy. As a result, the sebaceous glands are destroyed, the skin becomes dry, and even covering cosmetics will no longer adhere satisfactorily to it.

2. The second classification of hemangioma is the type generally known as the "strawberry mark," sometimes called "hypertrophic endothelial hemangioma." This name is suitable, because the underlying pathological histology is described by it.

Masses of endothelial cells are found displacing the skin and subcutaneous tissues. The prolifie growth of these cells is so great that many of the blood-vessel walls are compressed as the tumor grows, and appear only as fissures in the histological section.

This lesion, with its bright red, irregular top elevated above the surface of the normal skin, is clinically the most familiar of the three types. Frequently growth is rapid, and in two cases in our series in which twins were involved, the rapidity of growth appeared to be almost malignant in nature. Typical metastases have been reported in the literature.

The masses of endothelial cells which are shown histologically are of therapeutic and prognostic importance, for such undifferentiated tumors would be expected to be highly radiosensitive, and, as a matter of fact, they nearly always are.

3. "Cavernous hemangioma" constitutes the third classification. These deep tumors may be covered by entirely normal skin, but can usually be distingusihed through the overlying skin as a swelling which is purplish in color. Histologically, the vessels have the same juvenile type of endothelium which is found in the "strawberry marks," and are, accordingly, more sensitive to radiation and other forms of therapy than are the adult types of endothelium which appear in the port-wine stains.

TREATMENT

The treatment depends to a great extent upon the classification of the tumor. With capillary hemangiomata or port-wine stains, excision is usually the therapy of choice. Ultraviolet radiation is occasionally successful. Cosmetic covering pastes are often very satisfactory in women. The other main classifications consisting of the "strawberry marks" and "cavernous" types of hemangiomata can be treated in a variety of ways. Surgical incision can, of course, be used for any type of hemangioma. Frequently, however, these lesions are on the face, or are so large or are located so close to important vessels or nerves (especially the seventh), that excision is not practicable. After other methods have been used, surgery may be appropriate for excision of scar tissue in some cases.

Destructive methods are many in number, and are aimed chiefly at 'sclerosing the lining of the vessels. For this purpose fulguration with cautery, insertion of hot platinum needles, pressure to produce luceration, scarification, or even vaccination have been used. Injection with a great number of different substances, electrocoagulation, freezing with carbon dioxide snow, and x-rays and radium, are all in use at the present time.

Considering the number of methods which are available, it is important that the one be selected that will yield the best cosmetic end result. Most poor results are ascribable to two causes:

1. Watchful waiting on the part of the physician and family in the hope that the lesion will regress. Such regression occasionally occurs, but much valuable time is often lost while the lesion doubles or trebles its invasive growth during the futile period of waiting.

2. The wrong therapeutic agent is selected. Such wrong selections are usually made, because due concern is not given to the depth, extent, and particular type of lesion. Carbon dioxide snow or the beta rays of radium, for instance, are not suitable, and are even dangerous in the treatment of deep hemangiomata, yet they are all too frequently used in such cases.

The more common methods will be reviewed with particular attention to their applicability:

1. *Surgery.*—We believe the viewpoint that surgery should be employed in all cases is too radical. Selected cases, however, often lend themselves to easy surgical excision. Superficial lesions about the eyelids can usually be removed most easily by excision. Skin grafts can be substituted for large birthmarks, but the decision must be made as to whether the patchy appearance of a graft is more to be desired than the lesion itself, or the results obtained following the use of radium.

If the lesion is elevated, it is our belief that radon seeds should be implanted first, or that radium packs should be used as described later. If necessary the final skin result can be further improved by grafting.

2. *Electrocoagulation.*—Electrocoagulation has been recommended by Figi[2] for use in cavernous hemangiomata in adults as well as infants. The chief difficulty with this method is in gauging the intensity and extent of the coagulating process. Should this amount of cooking be too great, sloughs are likely to produce unsatisfactory scars.

3. *Sclerosing Solutions.*—The use of sclerosing solutions dates from almost 100 years ago when Pravez,[3] prior to 1845, injected ferric chloride of coagulation of blood in aneurysms and hemangiomata. Since that time acetate of peroxide of iron, hot water, alcohol, quinine hydrochloride and urethane, as well as innumerable other solutions, have been used. One-quarter to three c.c. of sodium morrhuate in five per cent solution is usually considered to be most advantageous, as recommended by Peyton and Leven,[4] as well as Watson and McCarthy.[1] Our experience with these methods has been somewhat limited and on the whole disappointing.

Unsatisfactory results from sclerosing solutions may occur as a result of sensitivity to the solution, in which case a generalized reaction may occur. Marked swelling usually ensues, and the possibility of infection and sloughs is always present. In hemangiomata in which the blood is circulating rapidly the sclerosing substances may be carried away before it has a chance to act.

4. *Carbon Dioxide Snow.*—Carbon dioxide snow was introduced as a freezing agent by Pusey in 1907, and still remains popular with dermatologists. Repeated applications of 7 to 10 seconds on small superficial hemangiomata of the hypertrophic endothelial type can be a satisfactory method of treatment. When too large a dose is used, blistering, and later scar formation, may occur as unsatisfactory results.

The most serious and most common error in the use of carbon dioxide snow is the attempted treatment of deep strawberry marks, or even cavernous hemangiomata. Under these circumstances the underlying tumor continues its destructive spread unchecked by the surface applications, even though the overlying skin may be treated so much as to show signs of damage.

5. *Radiation Therapy.*—Radiation, especially in the form of radium, is a most useful agent in the treatment of the hypertrophic endothelial or cavernous types of hemangiomata, if the proper method of application be employed. Since the sensitivity of vascular birthmarks to radium decreases inversely with the age of the patient, early treatment must be urged.

A. *X-ray Therapy.*—Many hemangiomata are exceptionally sensitive to radiation, and a trial of x-ray therapy is, therefore, sometimes warranted over very large lesions. Although Spencer[5] and others describe x-ray treatments as unfailing, this has not been our experience. We have caused large tumors to shrink by x-ray therapy, and have caused some of the smaller ones to disappear completely. In general, however, the results with x-ray have been less satisfactory than those obtained with radium.

Our results from x-ray therapy have not been uniform and have sometimes been disappointing, even when the dosage was raised to a point where the surrounding epiphyses, bones and other soft-tissue structures were getting amounts so large as to be a possible menace to normal growth.

Unsatisfactory results in the skin may be precipitated by small doses repeated too many times. Two cases treated elsewhere many years previously showed marked skin atrophy and malignant degeneration, which required excision and corrective surgery. For these reasons we are not satisfied with x-ray therapy alone for routine use in hemangioma therapy.

B. *Beta Rays of Radium.*—These rays are given off by unfiltered radium plaques or radon in glass applicators. They may be useful for small hemangiomata confined to the epidermal layers of the skin. The beta radiation which constitutes 96.5 per cent of the unfiltered radium output, is absorbed almost entirely by the superficial tissues and, therefore, has a very strong caustic effect on the outer layers of the skin. It is a dangerous mistake, therefore, to use unfiltered radium plaques for any but the most superficial lesions. If such beta ray therapy is employed for deeper lesions, unsatisfactory results may occur, because the skin may be severely damaged, while the deeper portion of the hemangioma receives relatively little irradiation and, therefore, continues to grow.

C. *Gamma Rays of Radium.*—These penetrating rays which are provided by properly filtered radium pack, are most useful, and frequently even deep hemangiomata disappear with such treatment. Although the dose to the skin must necessarily be somewhat higher than the dose to the tumor with radium pack therapy, the depth dose is still satisfactory. Many hemangiomata are so sensitive that one or two doses of 700 to 1,000 gamma roentgens[6] will precipitate disappearance of the vascular tumor without damaging the skin. To obtain gamma rays we favor the use of filtered radium packs at distances of three millimeters for superficial lesions and one to three centimeters for deeper lesions. The radium must be arranged in a geometrical design, so that all portions of the tumor are irradiated as evenly as possible. To the filter of 0.5 mm. of platinum (which stops all of the beta radiation), are added 1 mm. of silver and 0.5 mm. of brass as secondary filters. The total filtration effect, therefore, is that of 1 mm. of platinum with 0.5 mm. of brass as a secondary beta ray filter.

We have not seen any undesirable results from properly filtered radium packs. Often the skin returns entirely to normal, but when it does not, the pliable pinkish-white scar which usually occurs instead is not unsightly.

D. *Radon Seeds.*—Gold-filtered radon seeds with a wall thickness of 0.2 mm. of gold and a strength of ¼ to ½ mc., can be planted in an appropriate geometrical arrangement so that there is one in every cubic centimeter of hemangioma tissue.[6] The radiation distribution is such that the skin gets less dosage than the lesion, if the seeds are planted sufficiently deep.

Frequently a single implantation of radon seeds will be sufficient to cause the hemangioma to disappear—a matter of considerable importance to patients who have come from a distance and who cannot return for numerous treatments. These tiny gold radon seeds are not removed from the tissues, but we have seen no unsatisfactory results on this account except when too many seeds were planted, or the implantations were too close to the surface.

Since radon seed implantation is a relatively simple process which frequently requires only one patient visit, it seems to us the method of choice in the therapy of the deeper hemangiomata, although we generally use heavy filtered radium packs in a preliminary attempt to determine whether the lesion is unusually radiosensitive in nature and may respond to this somewhat simpler type of treatment.

CONCLUSIONS

1. Prompt treatment of hemangiomata is indicated, because most types are more sensitive to treatment when the patients are very young. Although spontaneous regression occurs rarely, much valuable time is often lost in vainly waiting for it while the hemangiomata increase their invasive growth.

2. Unsatisfactory results in the treatment of hemangiomata are most frequently caused by the selection of the wrong agent for the particular type of hemangioma involved.

3. The "strawberry mark," and the even deeper type of cavernous hemangiomata, respond well to irradiation. Although x-ray is often satisfactory, the gamma rays of radium in the form of well filtered radium packs have given, in our experience, more uniform results. The implantation of weakly gold-filtered radon seeds permits a very favorable distribution of the radiant energy. For this reason, and because frequent repetition is not required as with other methods, radon seed implantation is often the therapy of choice.

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SODIUM SULFADIAZINE IN THE TREATMENT OF MENINGOCOCCAL MENINGITIS*

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No deaths resulted in ten cases of epidemic meningitis treated with sulfadiazine exclusively, although six of these patients were in coma for an average of twenty-seven hours. There were slight transitory drug reactions in seven cases and temporary complications resulting from the disease in only three cases, but all patients returned to full duty in one month.

It was not until the advent of chemotherapy in the treatment of cerebrospinal meningitis and the preliminary report of the use of sulfonamides in humans by Schwentker, Gelman, and Long[1] in 1937 that the mortality rate was reduced to 10 to 12 per cent. Since that time the mortality rate has steadily decreased with this type of therapy.

CLINICAL PATHOLOGY

Although we have no autopsy material among our cases, we are aware that the pathological process appears to be readily explained by a septicemia followed by diffuse fibropurulent exudate in the meshes of the pia over the convexity and base of the brain and about the cerebellum and spinal

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* The opinions and assertions contained herein are the private ones of the writers and are not to be used as official or reflecting the view of the Army Department or the army service at large.

TABLE 1.—*Symptoms Report on Ten Cases of Cerebrospinal Meningitis**

Case Numbers	1	2	3	4	5	6	7	8	9	10
Age	26	24	19	25	20	20	19	19	22	22
Nasopharyngitis	—	+	+	—	—	+	+	—	—	+
Headache	+	++	++	+	++	+	+	+	+	+
Chills	+	+	+	+	+	+	+	+	+	+
Nausea and vomiting	+	+	+	+	+	+	+	+	+	+
Photophobia	+	+	+	—	+	—	—	+	—	+
Stiff Neck (subjectively)	—	+	—	+	—	+	++	—	—	—
Length of illness before hospitalization	36 hrs.	48 hrs.	24 hrs.	12 hrs.	24 hrs.	24 hrs.	48 hrs.	18 hrs.	24 hrs.	36 hrs.

* Symptoms of patients, in coma on admission, were obtained from Field Officers.

TABLE 2.—*Clinical Findings*

Case Numbers	1	2	3	4	5	6	7	8	9	10
Coma (length of time)	7 hrs.	—	24 hrs.	5 hrs.	—	—	—	*72 hrs.	*36 hrs.	*20 hrs.
Nystagmus, V Nerve	(Strabismus)	+	+	+	+	+	+	+	+	+
Conjunctivitis	—	+	++	—	—	+	+	—	+	—
Herpes labialis	—	—	+	—	—	—	++	—	—	+
Opisthotonos	—	—	—	—	—	+	+	—	—	—
Brudzinski	++	++	+	+	+	++	+++	+	+	+
Kernig	+	+	—	—	+	+	++	*?	*?	—
Hyperactive Tendon reflex	+	+	+	+	+	+	+	+	+	++
Babinski	—	—	—	—	—	—	—	—	—	—
Petechial rash, changing to purpura	—	+	+	—	—	+	—	+	++	—
Mild clonic twitching and hyperactivity	—	—	++	—	—	—	—	++	+	+
Temperature on admission	102°	102°	103°	104°	102°	99.6°	102°	104°	104°	101°
Tachycardia, followed by bradycardia	+	+	+	+	+	+	+	+	+	+

* In coma on admission.

TABLE 3.—*Laboratory Data*

Case Numbers	1	2	3	4	5	6	7	8	9	10
Blood count WBC	13,600 90-10%	30,000 84-14%	16,000 90-10%	29,800 87-13%	21,900 86-14%	30,100 89-14%	18,350 80-20%	23,500 84-15%	43,000 90-10%	29,800 90-10%
Urine	—	—	—	—	—	—	—	—	—	—
Kahn	—	+	—	—	—	—	—	—	—	—
Blood culture	—	—	—	—	—	—	—	—	—	—
Blood sugar	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal
Nasopharyngeal culture	+	+	+	+	—	+	—	*	*	+
Spinal Fluid: Pressure	280	170	310	350	325	290	350	300	400	420
Queckenstedt—normal										
Appearance	Turbid	Turbid	Turbid	Turbid	Turbid	Turbid	Turbid	Turbid	Turbid	Turbid
Count	560+ Pellicle 98% poly	1,800 100% poly	2,179 94% poly	6,250 97% poly	11,000 96% poly	1,980 91% poly	10,000 95% poly	2,850 94% poly	13,350 96% poly	10,000 90% poly
Sugar	65 mg.	83.3 mg.	71.4 mg.	35.9 mg.	62.5 mg.	5.8 mg.	6.0 mg.	62.5 mg.	40.2 mg.	26.0 mg.
Globulin	Neg.	Neg.	Inc.	Inc.	Inc.	Inc.	Inc.	Inc.	Inc.	Inc.
Smear	In. & Ex. Cellular	Ex. Cellular	In. & Ex. Cellular	In. & Ex. Cellular	Neg.†	Ex. Cellular	In. & Ex. Cellular	In. & Ex. Cellular	In. & Ex. Cellular	In. & Ex. Cellular
Culture	Neg. fluid	Pos.	Pos.	Pos.	Neg.	Neg.	Pos.	Pos.	Neg.	Neg.

* Unable to take smear.

† This case is carried as cerebrospinal meningitis because chemotherapy was started thirty-six hours before we saw him, and therefore we were unable to isolate organism.

TABLE 4.—*Subsequent Urinary Laboratory Data*

Case Numbers	1	2	3	4	5	6	7	8	9	10
Acetyl Sulfadiazine crystals	0	+	+	+	0	+	0	+	0	0
R. B. C.	Many	0	Many	Many	Many	Many	0	Many	Many	0
Albumen	++	0	+	+	++	++	0	+	+	++
Final urinalysis	—	—	—	—	—	—	—	—	—	—

cord, thus accounting for the neurological findings. Temporary conjunctivitis (Table 2) occurred in five of our cases, probably due to trigeminal[2] nerve irritation or local presence of Gram-negative diplococci, which we feel may also account for marked photophobia seen in six cases. Nystagmus from irritation or brief paralysis of the oculomotor nerves was found in all cases. Temporary deafness in the left ear of one patient occurred following involvement of the eighth nerve. Purulent arthritis[3] and synovitis were important phenomena[4] in two patients, one involving only the elbow, while the other had multiple joints affected, including both knees and right elbow, due to the septicemia.[5] Fever, chills, leukocytosis, and variable petechial rash (see pictures) which later changed to purpura,[6] were noted in five cases and were also undoubtedly due to the septicemia. The onset of the illness was initiated by nausea and vomiting in all our cases, which we feel is a paramount symptom, and has never been fully explained, but is probably due to central irritation.

TREATMENT

Although no antimeningococcic serum or meningococcic antitoxin was used, our findings concur with present statistics, that chemotherapy is far superior in the treatment of cerebrospinal meningitis to serum or antitoxin, and that sulfadiazine is the drug of choice. Serum therapy should be reserved for those patients who do not respond or are sensitive to the sulfonamides. Our patients did not fall into either category.

The fulminating nature of the disease requires emergency intravenous drug therapy immediately.

In the treatment we found the initial administration[7] of 5 grams of the sodium salt of sulfadiazine, in 1,000 c.c. of triple distilled sterile water, the best method of obtaining a high blood concentration early. This method of chemotherapy was forcibly impressed upon us by the first of six cases in coma which responded dramatically. We feel that not only the bacteriostatic action was accomplished, but also replacement of fluid lost in vomiting was obtained, and chances of renal complications obviated. In order to maintain an adequate blood level of the sulfonamide, we gave the second dose of one gram in two hours by mouth when possible, thus allowing for absorption time from the intestinal tract; otherwise in four hours intravenously. All subsequent doses of one gram were given every four hours. Although the temperature dropped by crisis in two or three days, this dosage was maintained in all cases for ten days. If the patient was symptom-free, the dosage was then divided into one-half gram every four hours for three days longer, and if at this time the patient was clinically well, the chemotherapy was withdrawn entirely,[8] except where complications intervened. This may be more concisely stated;[7] continuous drug therapy until temperature normal seven days. The average total dosage of sulfadiazine was 64 grams, and the blood level was between 5 and 12 milligrams per 100 c.c. of blood for the first two weeks. We feel that the slight toxic reactions of sulfadiazine and the negligible mortality rate makes sulfadiazine the choice of sulfonamides.

At least 3,000 c.c. of fluid was given daily either by mouth or, if parenterally, 3,000 c.c. of 5 per cent glucose in normal saline. Urinalyses were determined daily, but when albumen, red blood cells, or crystals of the acetyl compound were noted (Table 4), urine examination was then done on each consecutive specimen. Then fluids were further forced to 4,000 c.c. daily and one gram of sodium bicarbonate was given four times daily to maintain an alkaline urine, thus preventing the precipitation of acetyl-sulfadiazine.[9] No permanent kidney impairment resulted under this form of therapy and adequate blood levels were maintained for as long as three weeks in one case. Daily[10] complete blood counts were taken and no depression of consequence of the hematopoietic system occurred.

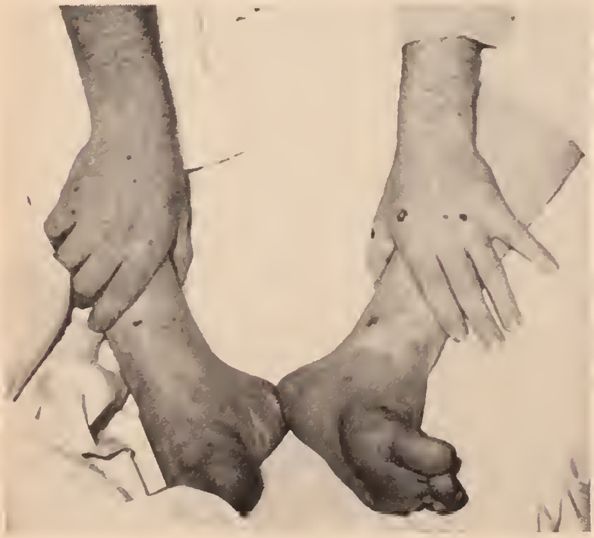

Fig. 1.—(Case 9) Petechiae after first twenty-four hours.

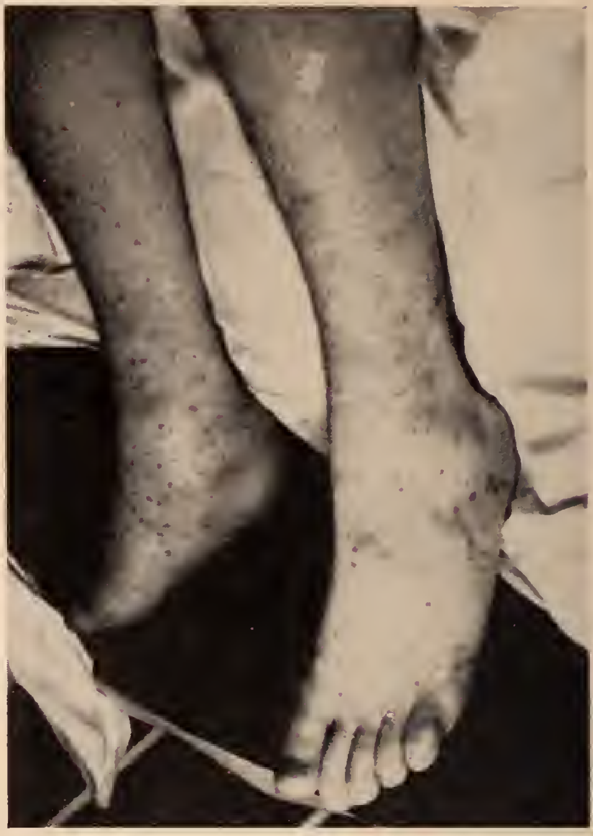

Fig. 2.—(Case 9) Petechial change after first twenty-four hours.

Blood sulfadiazine concentrations were made after the first twenty-four hours and continued on alternate days. Blood sedimentation rates were determined during convalescence, as we find from our 150 cases of chemotherapy-treated pneumonias it is an excellent criterion for complete cure before discharging soldiers to full field duty.

Chemotherapy in the treatment of cerebrospinal meningitis represents only one phase of the management of this condition. Early recognition of the symptoms (see Table 1) and prompt spinal fluid diagnosis (Table 3) are imperative. Isolation technique in a darkened quiet room offers the patient most comfort. Sedation proved to be one of the greatest problems; three of the six comatose patients had mild clonic twitchings or convulsive seizures for as long as seventy-two hours. Full restraints, even straitjackets were necessary, thus requiring alert nursing care and attention to bed and restraint sores. It was found that the patients had a high tolerance to barbiturates, either intravenously or intramuscularly. The barbiturates were used with caution, because bradycardia followed the initial tachycardia (see Table 2). For nourishment 5 per cent glucose in saline was given to the patients in coma, and a soft diet was begun as soon as the patient was able to be fed.

Criteria for further spinal punctures were persistent clinical symptoms, or evidence of marked intracranial pressure; but in our cases there was no evidence of spinal subarachnoid block. Subsequent spinal taps at the time of discharge we found to be of no clinical value because of negative spinal fluid findings.

The routine requirement of three negative nasopharyngeal cultures, five days apart, before discharge, was followed. All patients were seen on admission and discharge by a member of the neuropsychiatric and the eye, ear, nose and throat departments.

COMPLICATIONS

The average length of hospitalization was one month, except in three cases where complications occurred. One patient (Case 7) had temporary deafness of the left ear, lasting five days. Purulent polyarthritis and synovitis were noted in another patient (Case 6), involving the right elbow and both knees. Fifty c.c. of cloudy, straw-colored fluid containing many polymorphonuclear cells was aspirated from these joints and cultured, but no meningococci were grown or seen on smears, probably due to previous bacteriostatic action of chemotherapy. In a third patient (Case 2) monoarthritis and synovitis with effusion of the left elbow developed. There were slight joint residuals clinically. The elbows affected in both arthritic cases have 15 per cent limitation of extension at the present time, but orthopedic opinion is that full function can be expected. X-ray failed to reveal skeletal changes of any permanent significance in any of the involved joints.

SUMMARY

1. No deaths resulted in ten cases of meningococcal meningitis treated with sulfadiazine exclusively, although six of these patients were in coma for an average of twenty-seven hours.

2. Constant clinical findings were: headache, nystagmus, chills, fever, nausea, vomiting, and positive Brudzinski, substantiated by laboratory findings of high blood leukocytosis and spinal fluid with high leukocytic cell count and intracellular or extracellular Gram-negative diplococci.

3. In treatment sulfadiazine is the drug of choice, because of the slight toxicity, low mortality, prompt recovery, and minimum of complications. Although no serum or antitoxin was used, we concur with present statistics that serum or antitoxin therapy should be reserved for those remote cases of drug idiosyncrasies and those who fail to respond to chemotherapy.

4. The fulminating nature of the disease requires the immediate administration of 5 grams of sodium sulfadiazine intravenously for the initial dose in all cases to obtain early high blood concentration. This should be followed by one gram every four hours intravenously if the patient is in coma or vomiting, otherwise sulfadiazine one gram orally for at least ten days. With our patients the average total dosage of sulfadiazine was 64 grams, and the blood level was between 5 and 12 milligrams per 100 c.c. of blood for two weeks. Renal and toxic complications may be obviated by ample fluids, daily complete blood counts, urinalysis, and sodium bicarbonate.

5. Complications of the disease in our cases were few with sulfadiazine and do not appear to be of a permanent nature, purulent arthritis and synovitis being most common. Without complications the average length of hospitalization was one month, discharge being based on three negative nasopharyngeal cultures taken five days apart and normal blood sedimentation rates. The latter we found, from our 150 cases of chemotherapy-treated pneumonias, to be an excellent criterion for complete cure before discharge to full field duty.

Station Hospital, Camp San Luis Obispo.

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Relief of Allergic Premenstrual Headache.—Certain allergic women who suffer from premenstrual headache, premenstrual tension, and associated dysfunctional ailments were found to have sharply positive reactions to intradermal testing with a gonadotropic preparation, a 1:5 dilution of Synapoidin. Numerous controls made negative responses. Women showing positive reactions were relieved by intradermal desensitization with the same preparation. This method of test and treatment is simple, harmless, and effective.—E. W. Phillips, Phoenix, in *Southwestern Medicine,* June.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL NOTICES

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Thirteenth (313th) Meeting of the Council of the California Medical Association*

The meeting was called to order in conference room 8 of the Biltmore Hotel, in Los Angeles, at 10 a. m. on Sunday, October 10, 1943.

1. Roll Call:

Councilors present: Philip K. Gilman, Chairman; Karl L. Schaupp, Lowell S. Goin, William R. Molony, Sr., E. Vincent Askey, E. Earl Moody, Edwin L. Bruck, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Donald Cass, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and Secretary George H. Kress.

Councilor absent: Dewey R. Powell.

Present by invitation: L. A. Alesen, Vice-Speaker; Dwight H. Murray, Chairman of Committee on Public Policy and Legislation; Harold A. Fletcher, and Edward M. Pallette, California Chairmen on Procurement and Assignment for Physicians; A. E. Larsen, Secretary of California Physicians' Service; Clifford W. Mack, President of California Hospital Association; B. O. Raulston, Dean of University of Southern California School of Medicine; Eugene F. Hoffman, Assistant Medical Director, California Physicians' Service; Mr. John Hunton, Executive Secretary; Mr. Hartley F. Peart, Legal Counsel; Mr. Howard Hassard, Associate Legal Counsel; Mr. Ben Read, Secretary of California Public Health League; Wilton L. Halverson, Executive Officer of California State Board of Public Health; and Mr. Clifford Walker, Hospital Service of Southern California.

2. Minutes:

Minutes of the following meeting of the Council were submitted and approved:

(*a*) San Francisco meeting (312th) held on August 22, 1943. (Abstract printed in CALIFORNIA AND WESTERN MEDICINE, September, 1943, pages 170-173.)

3. Membership:

(*a*) A report of membership as of October 9, 1943, was submitted and placed on file.

(*b*) On motion duly made and seconded, it was voted that twenty members whose dues had been paid since the last Council meeting, held on August 22, 1943, were reinstated.

(*c*) Upon motion duly made and seconded, retired membership was granted to the following members, whose applications had been received in duly accredited form from their respective county societies: William T. Rothwell, Los Angeles County; Ernest Dwight Chipman, San Francisco County.

4. Financial:

(*a*) A report of finances as of October 9, 1943, was submitted and placed on file.

[†] For complete roster of officers, see advertising pages 2, 4, and 6.

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

(*b*) Report was made concerning income and expenditures for September and for nine months, as of September 30, 1943.

(*c*) A balance sheet as of September 30, 1943, was submitted.

Upon motion duly made and seconded, the above reports were received and placed on file.

5. **Public Relations Survey:**

A report of the Special Committee on Study of Public Relations (Doctors Askey, Cline, and MacDonald) was made by its chairman, E. Vincent Askey. Doctor Askey informed the Council concerning conferences with representatives of a nationally known firm whose members specialize as public relations advisors and councilors.

Mr. Jack Little, a representative of the public councilors firm of Foote, Cone and Belding, successors to the well-known Lord and Thomas group, then addressed the Council, outlining a skeleton plan of procedure that would be put into operation if the group he represented should be called upon to do the work. The survey would be presumably carried through in the name of the California Institute of Public Opinion, it being estimated that at least 5,000 personal interviews would be necessary in order to acquire a good cross section of California lay public opinion concerning the medical profession of the State and its own and public health work. This initial or preliminary survey would be made on a cost basis.

It was emphasized that it was desirable that, if such a plan was to be put into operation, time was somewhat of the essence and the planning should begin at an early date.

Discussion was participated in by Doctors Cline, MacDonald, Molony, Dewey, and other councilors.

Dr. Clifford Mack, President of the Association of California Hospitals, was invited to speak and stated he felt sure the hospital groups would be in full accord and hoped that it would be possible for the State Medical Association and the State Hospital group to work together in close interest.

Further discussion was participated in by Mr. Clifford Walker of the Hospital Service of Southern California, Dr. Dwight Murray of the California Medical Association Committee on Public Policy and Legislation, and others.

Doctor Molony mentioned a somewhat similar survey which had been undertaken by the National Physicians' Committee.

Upon motion by Cass, seconded by Goin, it was voted that the firm of Foote, Cone and Belding be employed to make the proposed survey. Dr. Axcel Anderson requested that his vote be recorded as opposed.

Mention was made of the fact that other public relations groups had been consulted, but that in this particular work it was believed the firm selected was in the best position to carry through. (Note: For editorial comment, see p. 255.)

6. **California Physicians' Service and Hospitalization Organization Liaison Activities:**

The Special Liaison Committee, consisting of Doctors Cline, MacDonald, and Dewey, submitted a report through its chairman, Doctor Cline.

Full discussion followed: Councilor MacDonald was reluctant to accept some of the changes that were a variation from the recommendations in the Mannix report. President Schaupp and others commented on special phases of the work. (Note: For editorial comment, see p. 253.)

The report, in its final form, follows:

CALIFORNIA PHYSICIANS' ACTIVITIES WITH REFERENCE TO COMBINATION WITH THE HOSPITALIZATION GROUPS

Part I—Initial Statement

A Council Committee, consisting of Doctors Frank MacDonald, Edward Dewey, and John W. Cline, appointed by Chairman Gilman, was limited in the scope of its investigation to consideration of the best means of accomplishment of the union between California Physicians' Service and a state-wide hospitalization company which is to be formed. This union is to be accomplished in the general lines of the Mannix report which has already been approved with modifications by the Council of the California Medical Association. Mr. Mannix has accepted such modifications and incorporated them as his own.

The recommendations of the Mannix report are ten in number:

1. The first recommendation concerns only the Hospital Service Plan.

2. We feel that recommendation No. 2 should be accepted by California Physicians' Service with one modification. It seems increasingly probable that the executive chosen by the Executive Committee would be a layman. It, therefore, would seem wise to have a medical director who would deal with purely professional matters, serving in an independent position and directly responsible to the Board of Directors of California Physicians' Service by way of the medical members of the Executive Committee. Otherwise, the second recommendation should be fulfilled by California Physicians' Service in its entirety.

3. The third recommendation, we believe, should be followed by California Physicians' Service in its entirety. This would result in reduction of overhead and greater efficiency of operation.

4. The fourth recommendation, which segregates professional services from the nonprofessional services, usually performed by hospitals should be carried out, and California Physicians' Service should issue a separate contract covering x-ray, medical anesthesia, and pathological laboratory services.

5. The fifth recommendation, which urges a detailed actuarial study of the plans now existent, is desirable and should be carried out if sufficient experience is available to warrant sound actuarial conclusions. It would be foolish to undertake an actuarial study unless the data be sufficient to warrant reliable conclusions. This is a matter which must be determined by actuaries themselves.

6. The sixth recommendation applies to the Hospital Plan directly, but also has an indirect effect upon the economic structure of California Physicians' Service. It is hoped that the hospitals and the Hospital Plan will cooperate in this matter.

7. The seventh recommendation, suggesting the expansion of California Physicians' Service and the new Hospital Plan to the States of Arizona and Nevada, has merit. It is desirable to have the activities of a voluntary prepayment medical plan in these states, but California Physicians' Service should not expand into such areas without agreement by the medical profession of these two states.

8. The eighth recommendation urges that all physicians agreeing to practice under the plan, and all hospitals agreeing to furnish service under the plan should contract to do so for a period of one year. It seems undesirable to limit the duration to one year, and we would suggest that such agreement continue indefinitely unless canceled after a minimum period of one year.

9. The ninth recommendation includes advisable methods of enlisting support of the public and giving the public a voice in the conduct of the affairs of both the hospitalization and medical plan. This seems highly desirable.

10. The tenth recommendation is likewise in the line of public relations and should be carried out.

* * *

Part II—Comment and Recommendations

The above recommendations are all based upon the assumption that a union between the consolidated single state-wide Hospital Plan and California Physicians' Service be accomplished. California Physicians' Service should make every effort to meet with and assist in the development of plans for the consummation of this object. We believe that it is inadvisable for California Physicians' Service to remain aloof until the Hospital Plan has been unified. California Physicians' Service should at once signify its intention of uniting with the unified Hospital Plan and should coöperate in every way to facilitate the merger of the three now existing plans.

It must be realized that the projected plan will not be immediately accomplished and that the three hospitalization organizations and California Physicians' Service have responsibilities which they have contracted to discharge. It will be necessary for all these to protect themselves and their subscriber members under the terms of their organizations and contracts.

It is our opinion that the coöperative venture will succeed only if designed for mutual advantage. It cannot be expected that the combined organization contemplated can continue operation if there is an effort on the part of California Physicians' Service or the Hospitalization Plan to take advantage of the other. In order to insure equity in the details of the organization, and with particular reference to financial allotment, it is suggested that a group of three public-spirited and fair-minded individuals, who have no direct interest in either organization and no preëxisting prejudices, should be chosen by the usual means of setting up arbitrating commissions. We further believe that California Physicians' Service and the Hospital Service Plan should make every effort to establish the joint organization by coöperation, conference, and negotiation. They should mutually bind themselves to submit to and abide by the decisions of the arbitration committee upon any matter in which agreement cannot be reached. We believe that in this way an impartial and unprejudiced arrangement can be made to protect the interests of all concerned.

In accomplishing the unification of the three hospitalization groups in California (Hospital Service of California, Hospital Service of Southern California, and Intercoast Hospitalization Insurance Association) and California Physicians' Service, it will be necessary for each organization to make extensive changes in by-laws and articles of incorporation.

It is suggested that in this process, California Physicians' Service should eliminate the present cumbersome method of choice of trustees and substitute therefor a plan of election which would create a board which would be more immediately responsive to the wishes of the professional members than is possible under the present plan. To this end the State should be districted and each geographical district should be represented. Representation should be in proportion to the number of professional members in each district, and reapportionment should be made at intervals of about three years. The method of election should be given careful thought, and consideration should be given to the desirability of choice of trustees of California Physicians' Service by the House of Delegates of the California Medical Association, the component county societies, or the Council of the California Medical Association. Under any plan, direct Council representation should be provided. To this end a specified number of trustees should probably be chosen by and from the Council of the California Medical Association..

* * *

Of recent date it has become increasingly evident that it would not be possible to accomplish the unification of the hospitalization plans and the amalgamation of a state-wide plan with California Physicians' Service by voluntary effort alone. Due to the pressure of the practice of physicians and the occupation of hospital executives with difficulties of administration, it appears that the project will fail unless other means are adopted.

It is, therefore, recommended:

1. That a ten-member committee be appointed consisting of:

(a) Three members of the California Medical Association Council, namely, the President, President-Elect, and Chairman of the Council;

(*b*) The President of the Association of California Hospitals and two members of the Board of Trustees designated by him;

(*c*) One representative appointed by and from the Boards of Directors of each of the hospitalization organizations, *i. e.*, Hospital Service of California, Intercoast, and Hospital Service of Southern California;

(*d*) One representative appointed by and from the Board of Trustees of California Physicians' Service.

2. That this Committee be empowered to employ a full-time executive secretary to work out the details of organization and do the actual work involved under the direction of the Committee, which should determine the policies to be followed in effecting the organization.

It is suggested that such an individual should be employed to accomplish the actual organization and that no offer of permanent employment be made until the work has been completed, but that in choosing the man to accomplish the groundwork, the Committee should bear in mind that, if satisfactory to all concerned, he might be the logical person to become the executive secretary of the combined organization.

It would seem preferable to choose a man from outside the State of California because of freedom from local prejudice.

Beyond these suggestions there is no intention of the California Medical Association Council to influence the choice of or the exact duties of such an organizer.

3. That the Council of the California Medical Association appropriate funds necessary to employ such a full-time executive secretary and establish an office in which he could work for a period of not less than three nor more than twelve months.

Respectfully submitted,

SPECIAL LIAISON COMMITTEE OF C. M. A. COUNCIL

By Dr. John W. Cline, Chairman
Dr. Frank A. MacDonald
Dr. Edward B. Dewey

* * *

Upon motion by Goin, seconded by Green, it was voted that the report of the Special Committee be received and its recommendations be accepted.

Upon motion by Cline, duly made and seconded, it was voted that the Council appropriate $1,500 a month for a period of three months to finance the organization work of unification of the hospitalization plans and California Physicians' Service; the Executive Committee of the California Medical Association to have the authority to extend the appropriation for a longer period if necessary, and to appropriate additional funds in any month to meet unforeseen expenses.

7. California Bureau of Vocational Rehabilitation:

The courtesy of the floor was granted to Mr. H. D. Hicker, Chief of the Bureau of Vocational Rehabilitation of the California State Department of Education. Mr. Hicker stated that the State Bureau was anxious to have the coöperation of the medical profession in its rehabilitation work among crippled citizens.

After discussion, upon motion duly made and seconded, it was voted that the Chairman of the Council be authorized to appoint a Special Advisory Committee of five members to the California Bureau of Vocational Rehabilitation. Committee consists of Drs. J. B. Harris, Sacramento, Chairman; E. Vincent Askey, Los Angeles; Gertrude

Moore, Oakland; John W. Cline, San Francisco; and L. C. Kinney, San Diego.

8. Federal Children's Bureau Maternity and Pediatric Plan:

The Federal Children's Bureau plan to provide maternity and pediatric service to the wives and infants of enlisted men, which had been discussed in previous Council meetings, was brought up for discussion. (References to former actions thereon: (*a*) 311th Council meeting of June 19, 1943, Item 7, pages 72-73, July issue of Calif. & West. Med.; (*b*) page 83, July Calif. & West. Med., letter sent to component county societies by Council Chairman Gilman; (*c*) 312th Council meeting. Item 5(a) page 171, September Calif. & West. Med.)

Resolutions of component county societies concerning the maternity and pediatric program of the Federal Children's Bureau (Sacramento, Yolo, Contra Costa, Solano, and Santa Clara counties) were submitted.

Wilton L. Halverson, Executive Officer of the California State Board of Public Health, was asked to discuss the subject of maternity and pediatric work in relation to the Federal Children's Bureau program.

Doctor Halverson stated that the Federal Children's Bureau had placed the responsibility of administration of its program upon the California State Board of Public Health, but that the Board of Health had been obliged to use its own funds for clerical and other services incident to carrying through the program.

In thirty-eight counties of California the program was in operation, and 150 hospitals had expressed willingness to participate, and of that number about three-fifths had submitted the necessary auditing statements concerning their maintenance costs, the same to be sent forward to Washington, D. C.

Doctor Halverson outlined the grants-in-aid which had been made, and stated that in October it was estimated that 3,000 obstetrical cases would be submitted in California, with an estimated appropriation need of $339,000. It was possible that there might be 30,000 obstetrical cases coming under this program during the year. If so, a three-million-dollar grant-in-aid would be needed to finance the service in California, the average cost thus far being $113; this being about $28, or 34 per cent above the average of cost procedures in other portions of the United States.

This allocation of medical care responsibility had been thrust upon the California State Board of Public Health, which primarily is interested in preventive medicine and not in medical care procedures. The responsibility had been accepted because of its emergency nature.

Doctor Halverson stated that the literature put out by the California State Board of Public Health calls attention to the fact that it is possible to carry on this work only because the members of the medical profession are themselves making generous donations in service, and that the financial compensation of the Federal Children's Bureau does not cover the costs for the professional services rendered.

The Council did not change its action previously taken wherein the decision concerning participation in the Federal Children's Bureau plan was left to individual members of the State Association. In regard thereto, the situation is as follows:

1. The California Medical Association has expressed approval of the objective to provide adequate maternal-pediatric care to the wives and infants of enlisted men;

2. The Council of the California Medical Association has *not* given approval to the regulations of the Federal Children's Bureau whereby the payments *must* be made to the attending physician;

3. Members of the California Medical Association are free agents in this work; each physician to decide for himself under what conditions he is willing to give the indicated professional services.

Since the physician has the privilege of deciding for himself whether he will or will not participate in the plan outlined by the Federal Children's Bureau, the following additional information is given:

(*a*) A physician is at liberty to sign Part II of the prospective mother's application (which she obtains from a local board of health, the same being a State Board of Health form), but in so doing, the physician obligates himself to give the professional services stipulated for the money consideration also outlined. Further, the physician agrees that he will not accept additional compensation for the said services from the patient or patient's family. Provided, that services rendered prior to the day the prospective mother signed the application, or for services not stipulated in the prenatal, confinement and postpartum agreement, may be charged against the patient. (It is important that the physician read the agreement and inform himself concerning the services he will be called on to render before he signs a prospective mother's application.)

(*b*) Members of the California Medical Association are also free to determine for themselves whether they will accept such patients as private patients, under agreements mutually agreeable between patient and physician; but in such cases the physician must refrain from signing the agreement which the health boards give to prospective mothers who make request therefor.

However, if this latter course of a personal arrangement is followed, it is important to remember that the prospective mother will not be entitled to hospitalization or other benefits included in the Federal Children's Bureau program.

9. Industrial Accident Commission — Industrial Fee Schedule:

Legal Counsel Peart made an oral report concerning conferences with representatives of the California State Industrial Accident Commission. He stated that the petition of the California Medical Association in which request is made for a revision of the fee schedules pertaining to professional services rendered by physicians is still under consideration. He stated that many factors enter into the problem. Because of changes in the State Board, it is somewhat difficult to secure a prompt decision in the matter.

10. Osteopathy in California:

Report concerning conferences with representatives of the Los Angeles College of Osteopathy was made by Councilor Goin. Council Chairman Gilman reported on the conference of September 30 which was had with the deans of the four Class A medical schools of California.

Dean B. O. Raulston of the University of Southern California School of Medicine reported on conferences with Los Angeles representatives and discussed also the rules of the Council on Medical Education of the American Medical Association and of the Association of American Medical Colleges, since it would be necessary to secure from these groups, approvals of proposed plans.

Report was made upon the informal suggestions made by the committees and representatives of the Los Angeles College of Osteopathy, the Osteopathic Association, and of the Alumni groups of the College.

Upon motion by Goin, seconded by Kneeshaw, it was voted that, if the California Osteopathic Association appoints a committee to take up the matters that have been the subject of discussions, the Chairman of the Council of the California Medical Association shall be authorized to appoint a similar committee to meet with the osteopathic committee in conference, for the purpose of discussing ways and means whereby further progress may be made in these matters.

Doctor Moody thought that time was of the essence in these matters, and submitted a motion, duly seconded, as follows:

Resolved, That the California Medical Association advocates union of the medical and osteopathic professions and that conferences toward that end be instituted, and that mutual steps be taken by the California Medical Association and the California Osteopathic Association to contact constituted authorities having relation to these matters in order that such union may be brought into being.

It was agreed that the committee previously appointed, consisting of Doctors Cline, Dewey, and Mr. Peart, be authorized to put the phraseology of the above resolution into proper form.

11. Procurement and Assignment:

Edward M. Pallette of Los Angeles was invited to address the Council concerning Procurement and Assignment Service activities. Doctor Pallette outlined the problems which had confronted Dr. Harold A. Fletcher and himself and stated that in his own group of fourteen southern counties a survey of civilian physicians had been made and that only in a few instances did conditions exist whereby the health of citizens in certain communities was in danger. He stated that every effort was being made to make available for the military forces physicians whose services in civilian practice could be spared.

12. Housing Projects in War Industry Areas:

A. E. Larsen, Secretary of California Physicians' Service, was invited to address the Council and outline the situations now existing in the Housing Project areas in San Diego, Alameda, and other counties.

Doctor Larsen informed the Council concerning a recent visit to Washington, D. C., and of other steps that had been taken.

It was stated that California Physicians' Service, which had been providing medical care in certain housing areas, had notified the Federal and local Housing Authorities that its contract to give such service would be terminated as of September 30, 1943.

In Washington the Federal Authorities made an emergency agreement for a sixty-day period under which California Physicians' Service would continue to give professional care; the new contract, however, exempting California Physicians' Service from certain types of medical service, such as obstetrics and certain surgical work. The arrangement was referred to as "Plan A."

The relative number of tenants who had signed for the California Physicians' Service service in the different areas was brought out and the complications which had arisen in connection with physicians in private practice who were called upon to give medical care in the housing areas, and likewise in relation to county society actions, were discussed.

Doctor Larsen stated that the commercial program of California Physicians' Service was going forward in good fashion; that the rural aid program had bright prospects, but that in the war industry areas, such as exist in the Housing Projects, it was not possible to forecast the future situations which may arise.

Councilor McClendon spoke at some length concerning the San Diego situation and the complications which had arisen in relation to California Physicians' Service and the general attitude of the local Housing Authorities in that area, which seemed to be not favorable to physicians in private practice. He stated he regretted to inform the Council that California Physicians' Service was not in much favor with the medical profession in San Diego County.

Councilor Green recounted the history of California Physicians' Service activities in the Vallejo area of Solano County and spoke of the conferences which had been held and the communications which had been received from the Housing Authorities.

Doctor Green stated, in criticism of California Physicians' Service, that it had failed to keep the county society informed when changes of considerable moment were made and that this had led to misunderstandings. Reference was made to the original agreement between the Solano County Medical Society and California Physicians' Service at a meeting of the California Medical Association Executive Committee held in Vallejo on September 8, 1942. (Reference in CALIFORNIA AND WESTERN MEDICINE for October, 1942, on page 248.)

13. Committee on Public Policy and Legislation:

Dwight H. Murray, Chairman of the Committee on Public Policy and Legislation, discussed the Wagner-Murray-Dingell bill (S. 1161; H. R. 2861). General discussion followed.

The suggestion was made that if the representatives of the Committees on Public Policy and Legislation of the constituent state associations of the eleven Pacific States could hold a conference it might be of real value in securing organized and harmonious coöperation from Congressmen of these eleven commonwealths.

Doctor Murray also stated that Mr. Ben Read, Secretary of the California Public Health League, was planning a visit to Washington, D. C., to get first-hand information concerning certain public health and medical practice measures, and that in due course reports would be submitted to the Council.

Upon motion by Schaupp, duly seconded, it was voted that the California Medical Association Council give its approval to the plan of having Mr. Read go to Washington.

14. Resolution on National and State Policy Administration with Report to California Medical Association House of Delegates:

Councilor Bruck introduced the following resolution:

Resolution

WHEREAS, The medical profession in America finds itself facing the most critical period in its existence; and

WHEREAS, The failure of maintenance of proper contact groups at the national capital, and the substitution therefor of feeble personal effort, has been a contributing cause to the conditions in which the medical profession finds itself; and

WHEREAS, Because of lack of understanding of basic issues and problems by certain officers of the American Medical Association, public opinion is ever turning against organized medicine; and

WHEREAS, These changes in public opinion allow various and certain pressure groups to advance their own selfish causes; and

WHEREAS, The political adherents of socialized medicine have seized upon the rising tide of public criticism against organized medicine in an effort to accomplish their own desires; and

WHEREAS, The unnecessary continuous defensive position of the officers of the American Medical Association makes it impossible for them to take leadership in bringing about proper general understanding of the real public needs with respect to medical care and progress; and

WHEREAS, The officers of the American Medical Association should long ago have taken a more constructive and aggressive lead in the study and organization of properly-conducted, medically-controlled, prepaid medical care plans, but have not done so, and instead have found themselves placed in an increasingly bad defensive position; and

WHEREAS, It is our belief that the archaic attitude of certain of the officers of the American Medical Association regarding future conduct of medical practice and care of the public health is born of lack of foresight, or of an overestimate of their ability to fend off any deviation from past practices; and

WHEREAS, All of the foregoing has a great influence on the part that medicine must play in postwar planning in order that control of health and medical care be placed in the hands of the experts, in this case, namely, doctors of medicine; now, therefore, be it

Resolved, By the Council of the California Medical Association that there shall be placed before the next House of Delegates of the California Medical Association a request that this Association's delegates to the American Medical Association House of Delegates urge the following action by that House of Delegates:

1. The replacement of certain of the officers of the American Medical Association, to include the secretary and the editor of the Journal;

2. That a contract for suitable and proper survey of public opinion regarding its attitude toward organized medicine, medical care and proposed medical legislation be undertaken;

3. That an analysis of such information obtained by a qualified corps of experts outside of the American Medical Association be made;

4. That the information and instruction received through such surveys and analyses be properly used and not discarded (in order to attempt to mould public opinion into proper form);

5. That a suitable contact organization be set up at the national capital to try to regain that confidence of the legislators which the medical profession has enjoyed in the past; and be it further

Resolved, That a copy of this resolution be sent all other delegates to the American Medical Association before the next session of the House of Delegates of the American Medical Association, with a plea to further the above actions in the House of Delegates of the American Medical Association.

* * *

Upon motion by Bruck, seconded by Cass, it was unanimously voted that the resolution be accepted and approved in substance, but that Councilors Bruck, Kneeshaw, and Legal Counsel Peart be authorized to make such changes in phraseology as may be deemed desirable.

15. Agricultural Workers' Health and Medical Association:

President Schaupp, who has been a member of the Board of Directors of the nonprofit, semi-governmental corporation known as the "Agricultural Workers' Health and Medical Association" since the work of providing medical care for migratory agricultural workers was instituted some years ago, addressed the Council and called attention to Section 3 of Public Law 45 (78th Congress, Chapter 82, First Session, H. J. Resolution 96).

He stated that the existing language of Section 3 (a) (2) which now reads "furnishing by loans or otherwise, of health and medical and burial services, training, subsistence, allowances, protection, and shelter for such workers and their families" should be supplemented with the following additional language "provided further that funds available to the Administrator may be used for providing health and medical services to other migratory workers and their families who have entered the area without recruitment or assistance of any government agency and have engaged in agricultural work and to whom adequate health and medical services are not otherwise available in the area where they are working." So that in entirety the new wording will read as follows:

Section 3 (a) (2) furnishing, by loans or otherwise, of health and medical and burial services, training, subsistence, allowances, protection, and shelter for such workers and their families; *provided further that funds available to the Administrator may be used for providing health and medical services to other migratory workers and their families who have entered the area without recruitment or assistance of any government agency and have engaged in agricultural work and to whom adequate health and medical services are not otherwise available in the area where they are working.*

Doctor Schaupp stated further that the present wording of the Act is so restrictive that it excludes from medical care all agricultural workers who do not receive their employment as a result of some activity of some of the government agencies financed by Public Law 45. This means that our own American agricultural workers who have sufficient initiative and ingenuity to develop employment resources of their own are denied medical assistance.

Upon motion duly made and seconded, it was voted that a communication, calling attention to the desirability of an amendment to Public Law 45, be sent in the name of the Council of the California Medical Association to the California Congressmen, requesting their support of the proposed amendment. (For editorial comment see p. 256.)

16. Resolution Concerning Plan for Medical and Hospital Care of Citizens in Low Income Bracket Groups:

Councilor Kneeshaw brought to the attention of the Council the need of the medical profession to develop a positive program for medical and hospital care of citizens in the low income bracket groups. This was particularly indicated because of the militant activities of proponents of plans of socialized medicine and allied interests.

Upon motion by Kneeshaw, seconded by Bruck, it was voted that a committee be appointed by the Council Chairman to study and develop plans for medical and/or hospital care of citizens in low income bracket groups, the Committee to submit such plan or plans in a report for consideration by the California Medical Association Council; it being understood that the Council would submit a supplementary report with its recommendations to the House of Delegates of the California Medical Association in which the delegates of the California Medical Association to the House of Delegates of the American Medical Association would be instructed to submit a proper resolution in regard to the principles involved to the House of Delegates of the American Medical Association in the hope that the national body representing organized medicine would, in turn, formulate a constructive plan in which harmonious programs would be outlined that could be carried through by the constituent state associations of the American Medical Association. Committee consists of R. Stanley Kneeshaw, San Jose, Chairman; Edwin L. Bruck, San Francisco; John W. Cline, San Francisco; Karl L. Schaupp, San Francisco; and William R. Molony, Sr., Los Angeles.

17. Permanente Foundation Hospitals:

Councilor Emmons called attention to conditions which had come into being in connection with the hospital erected for the care of workers in the Fontana Steel Mills of the Kaiser interests, located in San Bernardino County. The hospital was operating as one of the activities of the Permanente Foundation. (References in Council minutes to Permanente Foundation: CALIFORNIA AND WESTERN MEDICINE for December, 1942, on pages 344-345; for January, 1943, on pages 23-26.)

The complications which had arisen in connection with practice by the contract physicians operating in this hospital of the Permanente Foundation and members in private practice, and with relation to future disposition and possibilities were mentioned.

Upon motion by Kindall, seconded by Emmons, a committee consisting of Councilors Kindall, Emmons, and Bruck, was appointed to make a study and report to the Council concerning the Permanente Foundation activities with special relation to medical staff activities and affiliations.

18. **Time and Place of Next Meeting:**

Upon motion duly made and seconded, it was voted that the time and place of the next meeting of the Council be left to the decision of the Council Chairman.

19. **Adjournment.**

Philip K. Gilman, M. D., *Chairman*
George H. Kress, M. D., *Secretary*

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Acute Shortage of Doctors Is Feared

Signs indicate that the doctor shortage will grow more acute than ever, *The Journal of the American Medical Association* said recently.

On the basis of a survey by the U. S. Public Health Service, the War Manpower Commission, the Federal Works Agency, and the procurement and assignment service, it is stated that the armed forces have commissioned only slightly more than 80 per cent of their stated needs.

In addition, 80 per cent, or about 1,500 of the annual doctor output of the medical schools will be absorbed into service.

Even if the 1,500 remained and went into civilian practice, they would replace not more than half of the 2,500 to 3,000 doctors who die every year.

Mortality Statistics in World Wars I and II

There is no such thing as a nice war, and the allied powers have given up any idea of concealing its horrors from their people, but one particular horror of past wars has been reduced to a minimum in this one. The wounded soldier has a better chance.

The miracles performed by Army and Navy doctors and laboratory scientists have been mentioned before, and Rear Admiral Ross T. McIntire, Surgeon-General of the Navy and personal physician to President Roosevelt, has given some new information concerning them.

In the last war, 7 per cent of the men wounded in action died; in this war barely more than 2 per cent. That means that a wounded man has forty-nine chances to one in his favor in his fight to recover. And "recovery" means more than just living. Admiral McIntire says that, of the compound fracture cases in the last war, 12 per cent died and almost half were permanently crippled, while in this war not more than one per cent die and only 10 per cent will be disabled.

Blood plasma, sulfa drugs, penicillin, and speedy treatment tell the story, according to Admiral McIntire. They do not end the horror of war, but they are saving the lives and health of thousands of wounded who would have died or become helpless invalids in past conflicts.

Eye Defects Cause of Many Rejections

Army rejections among 18- and 19-year-olds are caused chiefly by eye defects among white youths and education deficiencies among Negroes, according to a report made by Colonel Leonard G. Rowntree of the Army Medical Corps Reserve; Kenneth H. McGill, and Thomas I. Edwards of Washington, D. C. It was based on record of induction centers in December, 1942, and January and February, 1943.

The report said 23.8 per cent of white youths were rejected and 45.5 per cent of the Negro youngsters.

Other than eye defects, reasons for rejection of white youths were, in order of occurrence: mental disease, muscle and bone defects, heart and blood defects, ear defects, hernia, neurological defects, educational deficiency, underweight, and mental deficiency.

The nine remaining causes for Negro rejections were: syphilis, heart and blood defects, mental disease, muscle and bone defects, hernia, eye defects, neurological defects, mental deficiency, and tuberculosis.

War Impairing Flyers' Hearing

In a speech before the national meeting of the American Academy of Ophthalmology and Otolaryngology, Dr. Walter Hughson of the Otological Research Laboratory, Abington, Pennsylvania, estimated there would be 250,000 cases of impaired hearing among service men resulting from the war.

"At the close of World War I there were an estimated 40,000 aural casualties of all degrees of hearing impairment," Doctor Hughson said.

"At the present moment there are six times as many men in the American armed forces as there were in the last war, and these scattered over the entire globe. On a purely numerical basis we may expect 250,000 aural casualties in this war. That the actual number will be much greater can hardly be questioned."

Asserting the medical treatment of deafness "is relatively unimportant and ineffective," he said it would be unlikely that any acquired war deafness will be amenable to surgery of any type other than that employed for correction of chronic infection.

"There is but one ready solution to this present and impending problem and that is the proper fitting of an adequate hearing aid," he said.

Subject: The Need for Protective Services in Time of War

Office of Civilian Defense
Washington 25, D. C.

To: Regional Medical, Nursing, Engineer, Gas and Rescue Officers.

From: Dr. George Baehr, Chief Medical Officer.

Rumors that civilian defense is no longer necessary have recently been spread by irresponsible persons. These rumors are thoughtless or calculatingly subversive, for they are not supported by Army authorities responsible for our coastal defenses nor by the present military situation.

Fortunately, the success of our armed forces overseas has saved us thus far from experiencing the horrors of enemy bombing to which the cities of our Allies are being subjected. In the opinion of the best military authorities our coastal areas and industrial centers will not be free of the danger of enemy attack from the air nor of widespread sabotage until the last day of the war.

Civilian defense is needed also as one of the essential measures for safeguarding internal security. This is especially true of the Emergency Medical Service. If we had not created a nation-wide organization for civilian defense two years ago, we would be obliged to organize one today for home security. Disasters of all kinds have increased because of the tremendous speeding up of our great industries, the overburdening of our railroads, and the inexperience of hundreds of thousand of new war workers. Our police, our fire departments, our public works and utility services, and our hospitals, upon which we depend for protection, are being increasingly depleted of trained personnel.

We must, therefore, strengthen our voluntary protective services throughout the land. Along the Pacific and the Atlantic coasts, these services must be especially strong in volunteer personnel and equipment to guard us against the hazards of enemy attack and sabotage until that day when the Army, itself, advises us that the danger is ended.

Medical Journals—For Colleagues in Military Service

In former issues, editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy, and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The addresses of the three libraries follow:

University of California Medical Library, The Medical Center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals via "Railway Express Agency," collect, to: California Medical Association Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261). The "Railway Express Agency" will call for packages and will collect costs from the California Medical Association. The Postgraduate Committee will forward to camps.

Military Clippings.—Some news items of a military nature from the daily press follow:

Areas to Coöperate in Medical Service

Chiefs of the emergency medical service operating in connection with the Riverside County Defense Council recently decided to adopt the mutual aid plan outlined by state civilian defense officials.

Under this plan, equipment and personnel, if and when needed in any one area, will be supplied from other areas in a systematic and efficient manner.

Presiding were Roger Abbott, regional protection officer; and Dr. Charles Sebastian of Pasadena, southern sector medical officer.

Attending, in addition to Riverside County physicians, were Ralph Hughes, chairman of the Riverside County Defense Council; and Dr. Warren F. Fox, county health officer and emergency medical service coördinator.—Riverside *Enterprise*, October 1.

Army Doctors Attend Wartime Graduate Medical Meet Here

To keep doctors now in the Army informed about the latest progress in medicine, arrangements have been made to conduct wartime graduate medical meetings at some of the larger Army hospitals. Hammond General Hospital is among these.

Conducted by professors of the various medical schools, the meetings are operated by committees appointed by the American Medical Association and the American College of Surgeons.

The first of these meetings at Hammond Hospital was held last week. Approximately 150 doctors attended. These included the medical officers at Hammond, medical officers from other Army stations in California and Nevada, and members of the Stanislaus and San Joaquin County Medical Societies.

Technical lectures were given by Drs. Thomas Addis, Albert Davis and Alfred C. Reed of the Stanford University Medical School, Drs. William Kerr and H. Glenn Bell of the University of California Medical School, and Dr. Edmund Butler, chief of the San Francisco Emergency Services.—Modesto *Bee*, October 15.

Not Enough Physicians

Reports are that by the end of this year the United States will have about 53,000 doctors in military service to care for the 10,800,000 men in the Army, and that there will be 108,000 doctors left in this country to care for the nation's 120,800,000 civilians.

Since the doctors remaining in civilian practice are not distributed exactly in proportion to population, the doctor-to-population ratio in many war-congested localities exceeds the 1 to 3,000 figure regarded as needed to insure a fair standard of care.

The armed services must have proper medical attention; there will be no division of opinion about that. There is no escape from the probability that there will be an insufficient number of physicians for the civilian population until the end of the war. The question is how to make the best of an unsatisfactory situation, and one way in which all can join, is for every individual to take unusual care of his health in order to minimize the demands on the medical profession.—Long Beach *Press-Telegram*, October 10.

COMMITTEE ON POSTGRADUATE ACTIVITIES[†]

Thirteenth Annual Midwinter Postgraduate Clinical Convention in Ophthalmology and Otolaryngology

January 17 to 28, Inclusive, 1944

AUSPICES OF THE RESEARCH STUDY CLUB OF
LOS ANGELES

* * *

Western Section meeting of the Triological Society, January 22 and 23. Members of the convention are cordially invited to attend.

Special course in "Applied Anatomy and Cadaver Surgery of the Head and Neck," January 28 to February 1, inclusive.

Examination of candidates by the American Board of Otolaryngology, February 2, 3, 4, and 5.

* * *

In certain parts of the country some well-meaning people have thought it best to discontinue scientific meetings on account of the war. The attitude of the Research Study Club is exactly the opposite. Whether the "protector" or the "protected"—and each of us is either the one or the other—total war means all of us. That side will win this war whose people are more wise, more alert, and more realistic. We are not defeated—nor do we intend to be. In this spirit, we will continue our postgraduate work throughout the duration—and after. By doing this we take our stand as a part of the great national plan to continue all wholesome activities as far as possible during this time of trouble.

This preliminary announcement gives the general outline of the courses. As soon as all final details are completed, we will issue the usual complete booklet program. Those desiring the final program will please write to The Research Study Club, 2509 West Washington Boulevard, Los Angeles.

This year New York City provides the two principal teachers—Isidore Friesner and James Watson White.

As all know, Doctor Friesner has always been an outstanding teacher. He will give the results of his rich experience through many years in the practice of Otolaryngology.

Lectures will also be given by members of the American Board of Otolaryngology, including Dr. Thomas E. Carmody, Denver; Dr. Frederick T. Hill, Waterville, Maine;

[†] Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Dr. Dean M. Lierle, Iowa City; Dr. Carl H. McCaskey, Indianapolis; Dr. Arthur W. Proetz, St. Louis; Dr. Robert F. Ridpath, Philadelphia; Dr. Le Roy A. Schall, Boston; and Dr. John J. Shea, Memphis.

Dr. James Watson White of New York and Dr. Georgiana Dvorak Theobald of Oak Park, Illinois, will be the principal speakers on Ophthalmology. Irving B. Lueck, M. S., of Rochester, New York, whose lectures on prescription analysis have been so enthusiastically received, has been invited to participate again. Dr. Meyer Wiener will add to his already generous contributions on surgery of the eye.

At the suggestion of Doctor White, there will be made available to all who register for the Clinical Course copies of Duane's Thesis on Motor Anomalies of the Eye. Those desiring copies please enclose the sum of two dollars in addition to the registration fee.

Various other subjects pertaining to eye, ear, nose, and throat will also be given by representatives of the Medical and Technical Schools in Southern California.

As always, in deference to requests from the majority of those who have taken this course, the first week is devoted largely to the eye and the second week to the ear, nose and throat, so that those of us who confine our work to only one of these specialties can complete most of the subjects in only one week.

Many of those in all parts of our country and Canada possess motion pictures, specimens, plates, films and other treasures that can be shown for the benefit of all, and perhaps copies can be made of some of them to add to the library of our club. Everyone having something to show should write soon to Dr. Kenneth C. Brandenburg, 110 Pine Avenue, Long Beach, California, telling him the exact nature of the presentation and the length of time necessary, so that a definite place can be assigned on the program.

The fee for the Clinical Course is $50, one-half being due when you apply to take the course and the remainder upon registration. This is payable to Pierre Violé, M. D., 1930 Wilshire Boulevard, Los Angeles. It will be advisable to write at once for accommodations direct to H. M. Nickerson, Manager, Elks Club, Douglas MacArthur Park, Los Angeles, who will arrange to take care of as many as possible in the club itself. . . .

The special course in "Applied Anatomy and Cadaver Surgery of the Head and Neck" will be given again, directly after the Clinical Course. Dr. Simon Jesberg, whose gifts as a teacher and clinician we already know, will conduct this course in association with Dr. S. A. Crooks, Professor of Anatomy at Loma Linda College of Medical Evangelists. Doctor Crooks will demonstrate all anatomic relations in the different fields of head and neck surgery. As before, this course promises to be one of special practical value.

The Cadaver Course will begin at the conclusion of the Clinical Course (on January 28, 1944), and will carry into the following week—thus avoiding any conflict with the didactic lectures and the regular work of the clinical course. Twenty cadavers are available. This course is restricted to forty members—two to each table. The fee is $50. In order to register for this special course, kindly send $25 when registering for the Clinical Course and pay the other $25 at the opening of the course. Naturally, the members will be enrolled in the order of registration. In the future it may be possible to have a larger group, but this year only forty members can be provided for in the Cadaver Course.

The fee for the Clinical Course is $50. The fee for the Cadaver Course is $50. All those in active military service may enroll for the clinical course without the payment of a fee; and for the Cadaver Course for the payment of one-half of the regular fee—namely, $25.

Examination of candidates by the American Board of Otolaryngology will follow the Cadaver Course, on February 2, 3, 4 and 5. All prospective candidates should write immediately to Dean M. Lierle, M. D., Secretary of the Board, University Hospital, Iowa City, Iowa.

Years ago, when Col. Robert E. Wright came to us from India, the plans were made by a member of our club, Dr. Harry Gradle of Chicago. In Lund, Sweden, two of our members, Dr. Arthur Proetz of St. Louis and Dr. Howard House of Los Angeles, called on Dr. Gosta Dohlman and made all the arrangements for him to come to our course. No matter where he lives, each one who has enrolled is a member in good standing of the Research Study Club.

At long last, we are beginning to accumulate some money. This money belongs to you. Beginning in a modest way, we want to endow research work in various localities, publish results and send, without charge, monographs and books to each member. Please let us have your ideas.

THE COMMITTEE.

* * *

The Thirteenth Annual Midwinter Postgraduate Clinical Course in Ophthalmology and Otolaryngology of the Research Study Club of Los Angeles will be given from January 17 to January 28, inclusive, 1944. It will be followed immediately by the Special Course in Applied Anatomy and Cadaver Surgery of the Head and Neck.

The Club, always timely in its selection of topics and speakers, has been particularly fortunate in its selection of a faculty for 1944. Dr. James Watson White, of New York, and Dr. Georgiana Dvorak Theobald, of Oak Park, Illinois, will be the principal speakers on ophthalmology. Irving B. Lueck, M. S., of Bausch & Lomb, whose excellent lectures on Analysis of Presbyopic Prescription were heard last year, has been invited to participate again.

Doctor White plans to cover the motor anomalies of the eyes in a more comprehensive manner than is usually attempted in a short course. Sixteen hours of lectures will be given. Doctor White makes ingenious use of lantern slides projected upon a surface upon which he can draw with crayons to emphasize important points. In addition, there will be demonstrations by Doctor White and others of the use of the screen test, the screen comitance test and of loose prisms and other tests upon the results of which a sound diagnosis in motor anomalies must be founded.

Doctor White's name has become almost synonymous with motor anomalies in American ophthalmology. He has made this field especially his own and has been the teacher or guiding influence of most of the ophthalmologists who are doing the best work in this field today. His interest in the subject dates from 1913, and in March of 1914 he became associated with the late Alexander Duane. The association was so mutually agreeable that it persisted until Duane's death in 1926. Although Duane published his celebrated thesis, "A New Classification of the Motor Anomalies of the Eye, Based Upon Physiological Principles, Together with Their Symptoms, Diagnosis and Treatment," in 1896, the first edition of his translation of Fuchs's "Textbook of Ophthalmology" in 1892 and his well known chapter on the "Extraocular Muscles" in Poesy and Spiller's "The Eye and the Nervous System" in 1906, his work in the field of the motor anomalies would not be so well known today had it not been for Doctor White's continued interest in and teaching of the subject. The records of the American Board of Ophthalmology show that there is room for improvement in the teaching of this subject in most sections of the country. More candidates fail in motor anomalies than in any other subject, except pathology.

Doctor White is a talented teacher of long and varied experience. He was a clinical assistant at the Herman Knapp Memorial Hospital from 1914 to 1920 when he was appointed attending ophthalmologist and chief of the Vanderbilt Clinic, and consultant in ophthalmology to the Sloane Maternity Hospital.

Some years ago he resigned these positions to become professor of ophthalmology at the New York Postgraduate Medical School and Hospital. He is Director of the Ophthalmological Service and since 1930 has taught, personally, only motor anomalies.

His course in muscles at the Postgraduate School, which is given in the fall, is well known among ophthalmologists and at his Friday morning Muscle Clinics one may meet, for example, men from Florida, Canada and the West Coast, all in one day. His course in Los Angeles will contain substantially the same material that he uses in New York. The course is intensely practical and does not leave one with the vague feeling that one gets from a good deal that is taught and written on muscle anomalies, viz., that the subject is all, or nearly all, metaphysical.

A syllabus is in course of preparation which will enable the student to follow exactly the subjects under discussion and at the same time serve as a notebook.

Dr. Georgiana Dvorak Theobald became interested in eye pathology, as did so many others, from listening to the lectures delivered by the elder Fuchs when he came to America in 1922 and 1923. The simplicity and clarity of her demonstrations will strongly remind any one, who had the privilege of hearing him, of the great Fuchs. She is well known in the East and she needs no introduction to those who attended the midwinter course last year when she delivered one lecture on the general aspects of eye pathology.

COMMITTEE ON INDUSTRIAL PRACTICE

Big C. I. O. Health Conference in Los Angeles

On Sunday, September 19, the conference, "Health Joins the C. I. O.," will take place at the C. I. O. Building, 5851 Avalon Boulevard. The call to this all-day conference, asking for a minimum of four or five delegates from each local union and from all the shops in the Los Angeles area, states the purpose of this conference as follows:

"Health, or the lack of it, has long been a concern of union men and women. The war has only sharpened the need for labor participation in this field. Healthy workers mean uninterrupted production for victory. Inadequate health facilities and insufficient doctors in crowded war areas, a rising accident rate in industry and a deterioration of general community health must become key issues in a program for the unions."

"Can industrial health be improved through labor management committees on health? What kind of plans are available to provide medical care for workers and their families? What can be done about better health in the plants? What kind of health legislation do unions want?"

"These are the questions to which answers can be found only through a continuous program undertaken by labor itself. Discussion at the conference will contribute to set up such a program in an organized manner."

This, then, will be a working conference at which the delegates of the various unions will have a chance to set up a full-time health division within the C. I. O. Council, and to share in the planning of the program for such a division.

Noted Speakers

Leading national and local speakers have been secured who will discuss the various topics in the morning session, giving the delegates an opportunity to base their discussion during the afternoon panels on facts in health matters as they relate to the war effort and to a sound program for the years to come. Outstanding among the speakers will be Dr. Morris Raskin, Medical Coördinator of the Medical Research Institute of the N. A. W., and a pioneer in union health planning. His coming here has been made possible by the International of the N. A. W., who are paying Doctor Raskin's expenses. Doctor Raskin will discuss industrial health as it affects the workers, and how unions can help safeguard the health of their fellow workers. The topic of medical and hospital care will be discussed by Dr. Asher Gordon, resident physician at the Vallejo Housing Project and a member of California Physicians' Service, a prepayment group medical plan. Dr. Henry Borsook, Professor of the California Institute of Technology, and his coworker, Miss Nancy Upp. Field Director of the Los Angeles County and City Committee for Nutrition in Industry, will discuss how we can keep our workers at the highest level of efficiency through proper feeding methods in the plants.—San Pedro *Shipyard Worker*.

How Long Should a Man Work?

Somewhere there is a happy medium in the production period. If men work too long, they fatigue; and each task takes longer and longer until it is a losing battle. This, of course, does not even consider the poorer quality of work, the increased tendency toward accident or disease, and the steady rise in inefficiency.

On the other hand, if men do not work long enough, even though they do work efficiently, they cannot turn out the maximum number of units. There is man waste there—and again a losing battle. Somewhere between the two is the happy medium—the golden period where workers produce most without harming themselves or their product.

Now where is this period, important at any time in the smooth functioning of an industry, but especially important when a country is at war? A committee, representing the War and Navy Departments, the Maritime Commission, the Public Health Service, the War Manpower Commission, the War Production Board, and the Commerce and Labor Departments, studied the problem and here are its findings:

1. There should be a weekly day of rest. The Biblical injunction of one day's rest in seven seems to hold up after five thousand years. The seven-day work week for individuals is injurious to health, production, and morale. It slows down production because of the cumulative effects of fatigue when not broken by rest and relaxation. In fact, the workers take time off themselves. Too continuous work leads to increased absenteeism. Only in emergencies, and then for a limited time, should workers or supervisors (or doctors) forego their weekly day of rest.

2. There should be at least a thirty-minute meal period in midshift. Those working with toxic substances should be given sufficient time to cleanse their hands thoroughly before eating. (Physicians please note.) Also, there should be adequate food. Coffee and doughnuts for breakfast and a "coke" for lunch are not enough for a man or woman doing work.

3. The work-day should be eight hours long, and the week, six full days. Less than this makes for inadequate production. More than this, in time, results in impairing the health and efficiency of the workers and in decreasing the flow of production. Extra hours add little to output because the quality of work deteriorates not only during the extra hours, but also during the regular working hours; absenteeism rises sharply and accidents and illness increase.

4. There should be vacations completely away from the job. These vacations should be so staggered as not to delay production, and the period should be so balanced as to produce maximum benefit to the worker without too high a cost in productive hours lost.

Those are the recommendations, Doctor. How do they apply to your own practice and habits.—Norman R. Goldsmith, M. D., *Pittsburgh Medical Bulletin*.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

MATERNITY-PEDIATRIC PLAN OF FEDERAL CHILDREN'S BUREAU

(Additional items—Continued from pages 79-88, CALIFORNIA AND WESTERN MEDICINE, for July (Items I to XVIII); September, pages 178-182 (Items XIX to XXIII); and October, pages 226-231 (Items XXIV to XXX).

* * *

ITEM XXXI: MATERNITY-PEDIATRIC

Important Letter from California Medical Association Council to California Medical Association Members

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, October 22, 1943

The Members of the Component County Medical Societies
of the California Medical Association,
Addressed.

Subject: Maternity-Pediatric Program of the Federal Children's Bureau.

Dear Doctors:

This memorandum is sent to call attention to the action taken by the Council in regard to the Maternity-Pediatric program of the Federal Children's Bureau.

Following references are to special items in CALIFORNIA AND WESTERN MEDICINE, relating to actions taken by the California Medical Association:

July issue of CALIFORNIA AND WESTERN MEDICINE:

(*a*) Three hundred and eleventh Council meeting of June 19, 1943. Council resolutions appear under Item 7 on pages 72-73. (Appears also on page 81 as Item VI.)

(*b*) On page 83 is printed the letter of July 1, 1943, sent to the component county societies by Council Chairman Gilman. (Note: The second last paragraph was written in accord with the information at hand at that time.)

September issue of CALIFORNIA AND WESTERN MEDICINE:

(*c*) In the minutes of the 312th Council meeting, under Item 5(a) on page 171, the previous resolution was clarified by calling attention to a statement received from the California State Board of Public Health.

* * *

At the present time, the situation in California, in regard to maternity-pediatric work is as follows:

1. The California Medical Association has expressed approval of the objective to provide adequate maternal-pediatric care to the wives and infants of enlisted men.

2. The Council of the California Medical Association has *not* given approval to the regulations of the Federal Children's Bureau whereby the payments *must* be made to the attending physician.

3. Members of the California Medical Association are free agents in this work; each physician to decide for himself under what conditions he is willing to give the indicated professional services.

Since the physician has the privilege of deciding for himself whether he will or will not participate in the plan outlined by the Federal Children's Bureau, the following additional information is given:

(*a*) A physician is at liberty to sign Part II of the prospective mother's application (which she obtains from a local board of health, the same being a State Board of Health form), but in so doing the physician obligates himself to give the professional services stipulated for the money consideration also outlined. Further, the physician agrees that he will not accept additional compensation for the said services from the patient or patient's family. Provided, that services rendered prior to the day the prospective mother signed the application, or for services not stipulated in the prenatal, confinement and postpartum agreement, may be charged against the patient. (It is important that the physician read the agreement and inform himself concerning the services he will be called on to render, before he signs a prospective mother's application.)

(*b*) Members of the California Medical Association are also free to determine for themselves whether they will accept such patients as private patients, under agreements mutually agreeable between patient and physician; but in such cases, the physician must refrain from signing the agreement which the health boards give to prospective mothers who make request therefor.

However, if this latter course of a personal arrangement is followed, it is important to remember that the prospective mother will not be entitled to hospitalization or other benefits included in the Federal Children's Bureau program. (Note: This letter will be printed in CALIFORNIA AND WESTERN MEDICINE for November.)

If additional information is desired concerning the Federal Children's Bureau program, the physician should consult the health departments (preferably his local health department; or the California Bureau of Maternal and Child Health: 739 Phelan Building, 760 Market Street, San Francisco, 2, California; or, State Office Building, 217 West First Street, Los Angeles; or, 631 J Street, Sacramento).

Cordially yours,
KARL L. SCHAUPP, M. D., *President*
PHILIP K. GILMAN, M. D., *Council Chairman*
By GEORGE H. KRESS, M. D., *Secretary*.

ITEM XXXII: MATERNITY-PEDIATRIC

Maternity Care Funds Available

Resumption of the emergency maternity and infant care program (EMIC) is announced by Dr. Wilton L. Halverson, Director, California Department of Public Health.

Government-paid maternity care for wives of service men and medical care for their sick infants is available under the program which started in July and is now operating in thirty-five counties. Suspended on September 15, due to lack of funds, resumption is possible with telegraphic information from the United States Children's Bureau that funds are available immediately from a new congressional appropriation of $18,600,000.

The State Health Department has asked for an immediate grant of $461,606 to pay for the care of individuals whose applications already have been approved and to provide care through October, Doctor Halverson said.

High Medical Cost

"The United States Children's Bureau has been notified that, due to the large number of service men's wives living in California and the high cost of medical care here, it is estimated that $4,000,000 will be required to carry the program in this state through the 1943-44 fiscal year.

"Spread of the program to other counties in the state is awaiting completion of satisfactory arrangements with local health departments, physicians, and hospitals. Payment for care is made to doctors, hospitals, and private health agencies on a cost basis by health departments which administer the program."

Any woman, irrespective of her legal residence, whose husband is an enlisted man in the fourth, fifth, sixth, or seventh grades in the Army, Navy, Marine Corps, or Coast Guard, is eligible under the program for medical and hospital maternity care without cost to the family. Care is provided throughout pregnancy and for six weeks after delivery as well as at confinement. Any infant under one year whose father is a service man in these grades is entitled to care for serious illness.—Los Angeles *Citizen*, October 8.

ITEM XXXIII: MATERNITY–PEDIATRIC

Resolution Adopted by the San Francisco County Medical Society

The following resolutions were adopted at the meeting of the Board of Directors of the San Francisco County Medical Society held on October 5, 1943:

Resolved, That the San Francisco County Medical Society highly approves the plan of the Federal Childrens' Bureau to provide obstetric and pediatric care to the wives and children of the enlisted personnel of our armed forces. These people should have the best medical care that can be obtained, regardless of cost or their ability to pay; and be it further

Resolved, That the San Francisco County Medical Society believes that these people will not receive the best of medical care because they will not have free choice of physician and hospital, since only those physicians and hospitals who are willing to participate in this plan are available to them; and be it further

Resolved, That the San Francisco County Medical Society disapproves the undemocratic principle of any government agency establishing fees for services rendered by one individual to another.

ITEM XXXIV: MATERNITY–PEDIATRIC

Resolution Adopted by Placer-Nevada-Sierra County Medical Society

Whereas, The members of the Placer-Nevada-Sierra County Medical Society approve, in principle, the Federal Children's Bureau Plan for Maternity and Infant Care for wives and children of certain groups of enlisted men; and

Whereas, The members of the Placer-Nevada-Sierra County Medical Society agree, because of the present emergency, to coöperate in this plan for a limited period of time; and

Whereas, The members of the Placer-Nevada-Sierra County Medical Society are opposed to the type of contract proposed by the Federal Children's Bureau, particularly that part of the contract which specifies that the fee for obstetric care shall be paid directly to the Doctor; and

Whereas, The proposed scheme of medical care and hospitalization appears to be but the opening wedge for the introduction of socialized medicine; now, therefore, be it

Resolved, By the members of the Placer-Nevada-Sierra County Medical Society, at its meeting on September 5, 1943, that the said Society express its opposition to the proposed method of payment of fees; and be it further

Resolved, That the Secretary be instructed to petition the Council of the California Medical Association and the Board of Trustees of the American Medical Association that they make every effort to see that such changes are made in the Federal Children's Bureau Plan as to make the plan conform more closely to the ideals of organized medicine.

* * *

The foregoing Resolution, upon motion duly made, seconded and carried, was adopted by the Placer-Nevada-Sierra County Medical Society at a meeting held in Auburn on September 5, 1943.

ITEM XXXV: MATERNITY–PEDIATRIC

Resolution Adopted by the Riverside County Medical Association

At a regular meeting of the Riverside County Medical Association held on October 11, 1943, the plan of the Federal Children's Bureau Plan of Obstetrics and Pediatrics care for wives and children of enlisted men in the armed forces was discussed and a motion was made and carried, a copy of which is as follows, for your consideration.

"Moved and seconded that this Association go on record that no member of the Riverside County Medical Association sign any slip which entitles the doctor to accept any fee for the care of these cases from the Government. Carried."

It should be added here that this Association does not oppose hospitalization of these patients through Federal funds. Furthermore, our members have expressed their willingness to care for these patients according to any financial arrangement that may be agreed upon between the doctor and the patient.

In effect, the members of the Riverside County Medical Association will continue to carry on the practice of medicine in accordance with the sentiment expressed above until at such time the Council of the California Medical Association may offer a final solution, and we urge the Council to take a definite stand and we also urge other county associations to take similar action.

We wish to state that we are willing to abide by the decision of the Council of the California Medical Association.

October 19, 1942.

ITEM XXXVI: MATERNITY–PEDIATRIC

Resolution Adopted by the Los Angeles Obstetrical and Gynecological Society

Whereas, Congress has enacted a grant-in-aid law designed to provide maternity-pediatric care for the wives and infants of enlisted men, an objective with which members of the medical profession are in full accord; but

Whereas, The Federal Children's Bureau of the Department of Labor, to which agency the administration of the law has been given, has seen fit to lay down rules and regulations which will undoubtedly make for maternity-pediatric care of poorer quality than is now rendered by physicians, thus defeating in part the primary purpose of the law; and

Whereas, The arbitrary establishment by the Federal Children's Bureau of below cost fee schedules for the professional services to be rendered not only makes for professional service of poor quality, and at the same time penalizes the medical profession whose members gratuitously and gladly give to the Government professional services in the examinations of selectees under the Selective Service Act which, if translated into money, would amount to millions of dollars; and

Whereas, In war industries a cost plus instead of a cost minus system is in full operation for citizen groups who have given no such massive contribution to the Government as have members of the medical profession; and

Whereas, The evils in the system that has been formulated by the Children's Bureau could be done away with in good part, if the grant-in-aid payments were made, not to the attending physician direct, but to the wives of the enlisted men, the patients to make their own financial arrangements with their attending physicians; be it

Resolved, By the Council of the Los Angeles Obstetrical and Gynecological Society, a group of more than one hundred specialists in obstetrics working in Southern California, a majority of whom have been certified by the American Board of Obstetrics and Gynecology that, on behalf of its members, full approval of the objective of adequate maternity-pediatric care for the wives and infants of enlisted men is given; and be it further

Resolved, That it is the opinion of this body that the best professional and other interests of the wives and infants of enlisted men would be served if the law of the Federal Children's Bureau plan would be changed to permit the grant-in-aid payments to be made direct to the wives of enlisted men instead of to the attending physicians; and be it further

Resolved, By the Council of the Los Angeles Obstetrical and Gynecological Society that the Councils of the California Medical Association and the Los Angeles County Medical Association be informed that the members of the Los Angeles Obstetrical and Gynecological Society prefer to render these professional services without pay to the wives of enlisted men who are deserving rather than accept the fee schedule, contract, and other procedures of the Federal Children's Aid Bureau; and

Resolved, That the Council of the California Medical Association be requested to take promptly all necessary steps, by letter if necessary, in addition to what may appear in the OFFICIAL JOURNAL to inform all members of the California Medical Association concerning the procedures to be preferably followed in relation to this maternity-pediatric work in this State; and

Resolved, That copies of this resolution be sent to the following:

The United States Senators and Congressmen from California. The officials in the United States Department of Labor and Children's Bureau who have charge of the administration of the Act; the California State Board of Public Health members; the officers of the American Medical Association (trustees, secretary, and editor); the secretaries, and editors of the State Medical Associations; the Obstetrical Societies in the different States of the Union; the Pacific Coast Obstetrical and Gynecological Society; and the American Board of Obstetrics and Gynecology.*

WAGNER-MURRAY-DINGELL BILL

(S. 1161; H. R. 2861)

Resolution Adopted by the American Bar Association

The following resolution, presented to the American Bar Association by Loyd Wright, Los Angeles attorney, was adopted by that Association:

Resolved, That the Board of Governors be requested to immediately appoint a special committee to study, analyze and investigate Senate Bill 1161 and that the Board of Governors give publicity to the recommendations and findings of such special committee and the action of the Board of Governors taken thereon; be it further

Resolved, That the House of Delegates is opposed to any legislation, decree or mandate that subjects the practice of medicine to federal control or regimentation beyond that presently imposed under the American system of free enterprise.

Wagner-Murray-Dingell Bill—"Cradle to Grave" Measure (S. 1161; H. R. 2861)

The analysis of features of the Wagner Bill (S. 1161; H. R. 2861) which follows has been printed by the California Public Health League. It is here presented for its informative items:

(COPY)

And Now It Is a Sickness Tax!

The medical bills of 110,000,000 people will be placed on the shoulders of the taxpayers under provisions of the Wagner Bill (Senate Bill 1161) now pending in Congress.

This scheme to socialize medical, dental, hospital and nursing care was introduced in the United States Senate on June 3, 1943, by Senator Robert F. Wagner of New York—for himself and Senator James Murray of Montana. It would broaden the Social Security Act by—

1. Imposing a tax of 6 per cent on the wages of all persons earning up to $3,000 per year. This is in addition to the present 20 per cent income tax and many other deductions from the weekly or monthly pay check.
2. Imposing a similar tax of 6 per cent on the employers.
3. Imposing a tax of 7 per cent upon self-employed individuals on the market value of their services up to $3,000 per year.

A TOTAL TAX OF $12,000,000,000 (TWELVE BILLION DOLLARS ANNUALLY).

A Federal Bureau Will Control All Health Services!

This scheme to socialize medical, dental, hospital and nursing care would be under complete control of the Surgeon-General of the Public Health Service.

The Surgeon-General would have power and authority to—

1. Hire physicians and establish rates of pay—possibly for all physicians.
2. Establish fee schedules for services.
3. Establish qualifications for specialists.
4. Determine the number of individuals for whom any physician may provide service.
5. Determine arbitrarily what hospitals or clinics may provide service for patients.
6. *Arbitrarily assign you to a physician, if you fail to select one of your own choice.*

Dental and Nursing Service

Section 912 of the Bill provides: "The Surgeon-General and the Social Security Board jointly shall have the duty of studying and making recommendations as to *the most effective methods of providing dental, nursing, and other needed benefits not already provided under this title.*"

The Surgeon-General is to find a way to provide dental and nursing care.

"A Menace to Medicine"

(Here is what the San Francisco *Call-Bulletin* says about this scheme in its editorial columns of August 10, 1943):

"Hidden among the provisions of the Wagner-Murray bill to broaden the Social Security Act, which now is pending before the Senate, is one which effectually would destroy the free practice of medicine in the United States.

"It would accomplish this by placing the entire medical profession, including its schools, hospitals, and clinics, under the direct or indirect control of the Surgeon-General of the Public Health Service, and by adding to the burden of the taxpayers the medical bills of some 110,000,000 people.

"Under the system of socialized medicine which the Act would set up, the citizen would be deprived of his privilege of seeking treatment from a physician of his choice or at a hospital or other institution of his choice, and would be required to seek service from the doctor and institution indicated by the health service.

"The goal at which the bill is directed—adequate medical service for all—is most commendable, and is one toward which the free medical profession long has been striving and hopes soon to reach.

"But the socialistic approach of the Wagner-Murray bill is vicious, and every citizen should join with the medical profession in urging that the measure be rejected."

It Is Up to You

Do you want this tax saddled onto you? Do you want your health services regimented under a Washington Bureau?

Tell your Senators and Congressman!

California in Congress

Senators should be addressed in care of the Senate Office Building, and Congressmen in care of the House Office Building, Washington, D. C.

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* For Resolution XXXVII: Maternity-Pediatric program (Resolution of five Pacific states), see page 293.

Following is the roster from California with home addresses:

SENATORS:

Hiram W. Johnson, Mills Tower, San Francisco.
Sheridan Downey, Atherton.

CONGRESSMEN:

First District: Clarence R. Lea, 719 North Street, Santa Rosa.
Second District: Clair Engle.
Third District: J. Leroy Johnson, 1621 Argonne Drive, Stockton.
Fourth District: Thomas Rolph, 152 Twenty-eighth Avenue, San Francisco.
Fifth District: Richard J. Welch, 978 Guerrero Street, San Francisco.
Sixth District: Albert E. Carter, 552 Montclair Avenue, Oakland.
Seventh District: John H. Tolan, 1749 Pleasant Valley Avenue, Oakland.
Eighth District: John Z. Anderson, San Juan Bautista.
Ninth District: Bertrand W. Gearhart, 857 M Street, Fresno.
Tenth District: A. J. Elliott, P. O. Box 134, Tulare.
Eleventh District: George E. Outland, 539 East Micheltorena Street, Santa Barbara.
Twelfth District: H. Jerry Voorhis, R. F. D. 1, San Dimas.
Thirteenth District: Norris Poulson, 317 South Commonwealth, Los Angeles.
Fourteenth District: Thomas F. Ford, 940 North Benton Way, Los Angeles.
Fifteenth District: John M. Costello, 5771 Valley Oak Drive, Hollywood.
Sixteenth District: Will Rogers, Jr., 14253 Sunset Boulevard, Los Angeles.
Seventeenth District: Cecil R. King, 1152 West Eighty-eighth Street, Los Angeles.
Eighteenth District: Ward Johnson, 790 Santiago Avenue, Long Beach.
Nineteenth District: Chet Holifield, 500 South Montebello Boulevard, Montebello.
Twentieth District: Carl Hinshaw, 3053 Lombardy Road, Pasadena.
Twenty-first District: Harry R. Sheppard, Yucaipa.
Twenty-second District: John Phillips, 65 North Fourth Street, Banning.
Twenty-third District: Ed V. Izac, 5380 El Cajon Boulevard, San Diego.

Why Be "Copy Cats"?

The argument has been advanced that if one believes in a free public school system, one should not object to "free medicine" controlled and paid for by the State.

There is considerable difference between a public school system to give every individual a chance for mental equipment with which to earn a living and care for himself, and furnishing the individual, at State expense, the various necessities and luxuries of life.

"Cradle to the grave" security sounds appealing, but a nation which accepts that plan sells its independence and admits that its people cannot care for themselves.

The American medical system has been the wonder of this war. It was not developed or fostered by the State. It was the result of enterprise and initiative of American doctors who over a long period of years have been determined to make American medicine supreme.

American medicine probably gives more actual free service to those who need it than do the so-called socialized medical systems of foreign countries, which load the cost of their "free" service onto the individual in the form of special taxes.

Why should we in this country even consider disrupting the greatest medical system in the world to copy experiments of nations which cannot match ours in medical progress?

The Wagner-Murray bill now pending in Congress would regiment American doctors. This vicious measure should and must be defeated.—Editorial in the San Francisco *Commercial News,* October 18.

"Federal Medicine"

When Congress gets around to debating the new Social Security Bill, one item likely to encounter particularly heavy weather is the section entitled "Federal Medical Hospitalization and Related Benefits." This section provides for a federalized system of hospitalization and outside medical care which would be financed by a tax of 3 per cent on all wages and salaries up to $3,000 a year—one-quarter of the total Social Security tax. The proceeds of this tax will, of course, vary with conditions in industry. The income available for medical care has been estimated as high as $3,000,000,000 a year. Make it $2,000,000,000, and the Government could still hire every doctor in the United States at $5,000 a year, rent every bed in all non-Government hospitals, and have a goodly sum left over for subsidized research, administration, and other uses certain to occur to the gigantic bureaucracy which would have to be set up (*The Saturday Evening Post*).—San Francisco *Underwriters' Report,* October 14.

"Sheep Dip": Or Social Security Service and the Doctors

We are in receipt of a circular and booklet issued by the National Physicians' Committee for the Extension of Medical Service, apparently the first blast of the medicos and dentists against the "cradle to the grave" Social Security service.

It is to be deplored if this contest is to be regarded as one between the Government and the doctors. Those of us who furnish the blood and guts ought to have something to say, and what we say should be aplenty.

If the Government has to regiment us in some way and there is no escape, we wish it would commence somewhere else. There is such an intimate connection between us and our appendix that we would like to have the association disturbed only by our friends if segregation there must be.

When it comes to going under the ether and not being able to boss the job, our strong preference would be to have the incisions and perforations made by someone who has a personal or at least a professional interest in the case and who would feel deep chagrin should he omit to replace some of the reconditioned parts. Better yet, if our relations are such that we call him Jim and he calls us Pete. We don't crave to be checked in and checked out under a Social Security number or an auto license.

There isn't anybody we need so much as a doctor when we want a doctor, and there isn't any kind of doctor we want so much as one who will exert all the skill and science he possesses for which he expects and deserves to be paid promptly and well. A hospital is no place to hunt bargains.

Doctor Holmes said that if all the medicine were dumped into the sea it would be so much the better for men and so much the worse for the fish. If we are going to experiment, let us try that. The idea of being run through a physician's office like sheep through a trough of sheep dip does not appeal. We cannot expect much professional anxiety or interest for 75 cents. If that is all we have to spend, better to stay away from the doctor, whoever he is. We may recover anyhow.

Mixing politics with medicine or dentistry is like breaking an antique egg into an omelet; it spoils the dish. Imagine an ogre of a dentist bearing down on you and saying, "Now this is going to hurt—unless you vote for Doctor Geevum."—Riverside *Press.*

Group Medicine Progress Along American Lines Threatened by Bureaucratic Proposal

Few will disagree that the history of medicine in the United States is a consistent record of expanded service, scientific advance and social responsibility. We need only to look around us in this community to realize how thoroughly well our medical men and our officials responsible for community health have risen to their social responsibilities. The very best in medical care and hospital services and facilities have been provided, much at public expense. The burden of unforeseen emergency costs has been lightened by hospitalization insurance plans that do not destroy individual self-respect. The same is generally true throughout the nation. There is, of course, much yet to be done, but coöperative common sense is making progress in the American way without sacrificing the important personal relation between patient and physician and without relieving the patient of his own responsibility in providing, to the extent that he is able, for his own medical needs through participation in "group medicine" insurance plans built up by individual initiative and without arbitrary Government procedure.

One of these "protection in advance" groups, and there are many others, is the Blue Cross plan. This single plan already protects some 15,000,000 Americans against emergency hospital expense. The progress being made is real and built on sound American tradition.

Now this good work, this healthy progress which flows out of the best American traditions and engages the self-help impulses and love of independence so characteristic of Americans, faces the blight of Government competition of the bureaucratic variety.

A new Social Security bill is before Congress. In this bill is a section entitled "Federal Medical Hospitalization and Related Benefits." This section would be financed by a tax of 3 per cent on all wages and salaries up to $3,000 a year. Its proceeds would vary, naturally, with conditions in industry. The tax is one-quarter of the total Social Security tax and has been estimated to bring in as high as three billion dollars a year which, as the *Saturday Evening Post* reminds us, would give the bureaucrats of this vast scheme of state medicine as much money to spend as was considered sufficient to run the whole country some short fifteen years ago.

In view of the progress of group medicine, with its protection of professional standards, local administration and community responsibility, the whole grandiose scheme of centralized and arbitrary state medicine seems not only uncalled for, but enormously wasteful and dangerous. It is to be hoped that the medical profession, with its fine record of social service and often selfless devotion to human needs, will rally in opposition to this gigantic Santa Claus dream. The good and increasingly successful efforts of American medicine to meet the country's health needs deserve protection from the half-baked designs of political bureaucrats.—Oakland *Tribune,* October 2.

The British Medical Association and the Beveridge Scheme

The stand made by the representatives of the British Medical Association against the Government proposals has been described in a previous letter (J. A. M. A., July 10, p. 759). The discussions with the Minister of Health are concluded and the next stage is the issue by him of what is called "a white paper" surveying the position. The representatives of the Association urged on him that this paper should be confined to a statement of the problems and not commit the Government to any solution, thus facilitating frank discussion by the public and the profession. On the Minister's ruling, the discussions were confined to a consideration of a comprehensive health service available to the whole community. They ranged over a wide field, such as central and local administration, health centers, free choice of doctor, private practice, and remuneration.

The Council of the British Medical Association has reaffirmed certain basic principles laid down in the Association's "General Medical Service for the Nation," approved in 1938:

1. The system should be directed to the achievement of health and prevention of disease no less than to the relief of sickness.

2. There should be provided for everyone a family doctor of his own choice.

3. Consultants and specialists, laboratory and other auxiliary services, institutional provision when required, should be available through the agency of the family doctor.

These recommendations and the following further ones are submitted by the Council for consideration by the divisions of the Association:

The state should not assume control of doctors rendering personal service. It is not in the public interest to convert the medical profession into a salaried branch of government service.

Free choice of doctor should be preserved and the state should not invade the doctor-patient relationship. Free choice of doctor should be reinforced by a method of remuneration related to the amount of work done.

Consultants and specialists should normally be based on the hospital. For those who wish to be treated in private accommodation, whether part of a hospital or not, private consulting practice should continue as at present.

The central administrative body set-up for the medical service of the future should be responsible for all civilian health services. The minister to whom this body is responsible should be advised on medical matters, including personnel, by a medical advisory committee representative of the medical profession.

Locally, new administrative bodies, responsible to the central authority, should cover wide areas and should be representative of the community served and, in appropriate numbers of the local profession and voluntary hospitals.—From "Foreign Letters," in *The Journal of the American Medical Association.*

Health Peril Shown in Social Medicine Plan

Congressman Says Scheme Would Curb Research and Initiative

Washington, Oct. 1.—Vast numbers of American people may be sentenced to an early death if the radical planners pervading the Government shackle the medical profession in their scheme for State Socialism, Representative Joseph W. Martin, Jr., of Massachusetts, House minority leader, warned tonight.

Representative Martin issued a ringing denunciation of bureaucracy, and of the trend toward the destruction of the American form of government in an address before the Medical Society of the District of Columbia. He charged:

"For some years a small but powerful group in this country has endeavored to undermine American institutions, American ideals, and our American way of life. I do not believe it is an exaggeration to say that they are represented in every department of our Government.

The minority leader spoke at length on the dangers that State Socialism presents in the field of medicine. But he warned that what was true of medicine might be true of every other field of American life.

In the field of medicine, Martin said, physicians and researchers have materially increased the health and the life span of the average man and woman of the past. He said:

"You have been able to accomplish this because your profession has been free.

"It has been free to dare. It has been free to progress."—David Camelon, in the San Francisco *Examiner,* October 2.

RE: MIGRATORY AGRICULTURAL WORKERS: THEIR HEALTH CARE

Amendment to Public Law 45

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, October 21, 1943.

The Officers of the Component County Medical
Societies of the California Medical
Association,
Addressed.

Dear Doctors:

This memorandum is sent to call your attention to a letter dated October 18, 1943, which was sent to the U. S. Senators and Congressmen from California, and to Senator Claude Pepper of Florida. (A copy of the letter is enclosed.)

It calls attention to the need of amending "Public Law 45, Section 3 (a) (2)" so that agricultural workers who have secured work in agricultural pursuits through agencies other than the "Government Employment" Departments, would not be deprived of indicated medical care.

* * *

You may wish to send an air mail letter or telegram to the California Senators and the Congressman from your district, asking them to support the proposed amendment to the Public Law noted above. (The list of Congressmen is given on page 85 of the July, 1943, issue of CALIFORNIA AND WESTERN MEDICINE.*)

For such coöperation as you may be able to give, accept our thanks.

Cordially yours,
KARL L. SCHAUPP, *President.*
By GEORGE H. KRESS, *Secretary.*

* * *

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, October 18, 1943.

The Honorable Hiram W. Johnson
U. S. Senator from California
Senate Office Building
Washington, D. C.

Dear Senator Johnson:

This letter is written on behalf of the agricultural workers of California who have been served by the Agricultural Workers Health and Medical Association in the past. Our attention has been directed to the present situation by the medical members of their Board of Directors.

Your attention is called to that section of Public Law 45 regarding the migratory agricultural workers and their families who would be eligible for health and medical service.

The present wording of the Act is so restrictive that it excludes from medical care all agricultural workers who do no receive their employment as a result of some activity of some of the Government agencies financed by Public Law 45. This means that our own American agricultural workers who have sufficient initiative and ingenuity to develop employment resources of their own are denied medical assistance.

In order to broaden the scope of professional services to be rendered, a proposed amendment to Public Law 45, Section 3 (a) (2) has been suggested. The proposed amendment would be as follows, the amendments being in italics:

Section 3 (a) (2) furnishing, by loans or otherwise, of health and medical and burial services, training, subsistence, allowances, protection, and shelter for such workers and their families; *provided, further, that funds available to the Administrator may be used for providing health and medical services to other migratory workers and their families who have entered the area without recruitment or assistance of any Government agency and have engaged in agricultural work and to whom adequate health and medical services are not otherwise available in the area where they are working.*

* * *

The California Medical Association, an organization of some 7,000 licensed physicians and surgeons, through the Council, its constituted authority, requests your support of the proposed amendment.

May we express the hope that you will write us in regard thereto? Kindly address your communication to Karl L. Schaupp, M. D., President, California Medical Association, 450 Sutter Street, Room 2004, San Francisco, 8, California.

With thanks for your help in this,

Cordially yours,
THE COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION.
Karl L. Schaupp, M. D., *President.*
Philip K. Gilman, M. D., *Chairman.*
(Signed) George H. Kress, M. D., *Secretary.*

(REPLY)

UNITED STATES SENATE
COMMITTEE ON FOREIGN RELATIONS

November 2, 1943.

Karl L. Schaupp, M. D., President
The Council of the California
Medical Association
San Francisco 8, California

Dear Doctor Schaupp:

In response to your letter of October 18, I send you herein copy of bill introduced by me covering the amendment proposed in your letter. I will do what I can to secure the early consideration of this amendment.

Sincerely yours,
[Enc.] (Signed) HIRAM W. JOHNSON.

* * *

(COPY)

UNITED STATES SENATE
COMMITTEE ON FOREIGN RELATIONS

Thursday, October 28.

Senator Johnson: The California Medical Association asks this amendment:

The story is this: They say the present wording of Public Law 45, providing medical care for migratory agricultural workers, is so restrictive that it excludes from medical care all agricultural workers who do not receive their employment as a result of some Government activity; which means that our own American agricultural workers who have sufficient initiative to develop some employment resources of their own are denied medical assistance.

* * *

78th Congress
1st Session

S. 1493

A BILL

To amend section 3(a) of the joint resolution entitled "Joint resolution making an appropriation to assist in providing a supply and distribution of farm labor for the calendar year 1943," approved April 29, 1943, as amended.

By Mr. Johnson of California

OCTOBER 29 (legislative day, October 25), 1943

Read twice and referred to the Committee on Appropriations

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* In this issue the roster of California Congressmen appears on page 285.

78th Congress
1st Session

S. 1493

IN THE SENATE OF THE UNITED STATES

October 29 (legislative day, October 25), 1943

Mr. Johnson of California introduced the following bill, which was read twice and referred to the Committee on Appropriations.

A BILL

To amend section 3(a) of the joint resolution, entitled "Joint resolution making an appropriation to assist in providing a supply and distribution of farm labor for the calendar year 1943," approved April 29, 1943, as amended.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That subsection (a) of section 3 of the joint resolution, entitled "Joint resolution making an appropriation to assist in providing a supply and distribution of farm labor for the calendar year 1943," approved April 29, 1943, as amended, is amended by striking out the word "and" before the figure "(5)" in the last sentence in such subsection; and by striking out the period at the end of such sentence and inserting in lieu thereof a semicolon and the following: "and (6) furnishing, by loans or otherwise, of health and medical services to migratory workers engaged in agricultural work, and to members of the families of such workers, to whom adequate health and medical services are not otherwise available in the area where they are employed, whether or not such workers have been recruited or transported pursuant to this joint resolution."

* * *

Editor's note.—It is planned to have a companion bill submitted to the House of Representatives. Comment thereon will appear in the December issue of CALIFORNIA AND WESTERN MEDICINE.

Some Replies from Congressmen: Re Agricultural Workers' Program

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 22, 1943.

Dear Doctor Schaupp:

This will acknowledge a letter from Doctor Kress dated October 18, with reference to Public Law 45.

In reply, I should like to advise that I am in sympathy with the point of view brought out in the communication referred to and believe I can assure you of my favorable consideration when the matter comes before the House of Representatives for further action.

Trusting my attitude meets with your approval, and with best wishes to yourself and members of your organization, I am

Sincerely yours,

(Signed) JOHN Z. ANDERSON.

[Member of Congress, 8th District, California.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 25, 1943.

My dear Doctor Schaupp:

I am very much in favor of an extension of health and medical services financed by the Federal Government, and if an amendment to Public Law 45 is the best and most feasible way of bringing this about in relation to American agricultural workers I shall be glad to give it my support.

As you know, Public Law 45 makes an appropriation to provide a supply of farm labor only for the calendar year 1943. The question will undoubtedly come before the House again, and this would give an opportunity for offering amendments.

Sincerely yours,

(Signed) GEORGE E. OUTLAND.

[Member of Congress, 11th District, California.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 22, 1943.

George H. Kress, M. D., Secretary
California Medical Association

Dear Sir:

Your letter of the 18th, wherein you suggest an amendment to Public Law 45, Section 3 (a) (2), noted.

An amendment of this character should, in my opinion, be taken up with your National organization and have its Washington representative call upon the Legislative Committees of the House and Senate handling legislation of this character and route it through these two committees and then you will have a chance of amending the Act.

I will be very pleased to coöperate with your representative if he can find the time to call at my office on the subject.

Yours truly,

(Signed) HARRY R. SHEPPARD.

[Member of Congress, 19th District, California.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 23, 1943.

Dear Doctor Schaupp:

I am very glad to have your letter of October 18 regarding amendment to Public Law 45. I certainly feel that the migratory workers and their families are entitled to every possible health benefit, and will be glad to follow the recommendations of your organization.

Sincerely,

(Signed) BILL ROGERS.

[Member of Congress, 16th District, California.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 22, 1943.

Dr. George H. Kress, Secretary
The Council of the California Medical
Association

Dear Doctor Kress:

I wish to acknowledge your letter of October 18 written in behalf of the agricultural workers of California. Congressman John Phillips, former State Senator, is a member from California on the Agricultural Committee of the House, and I am turning over your letter to him, because he is in a better position to give you this information than I am.

With all good wishes, I am

Sincerely yours,

(Signed) NORRIS POULSON.

[Member of Congress, 13th District, California.]

United States Senate
Committee on Military Affairs

October 23, 1943.

Karl L. Schaupp, M. D., President
California Medical Association

Dear Doctor Schaupp:

Thank you for your letter of October 18, and you may be assured I shall be glad to support the proposed amendment to Public Law 45, Section 3 (a) (2) which has been suggested.

I would welcome hearing further from you of any action you may wish me to take in this matter.

Sincerely,
(Signed) Sheridan Downey.
[Member of United States Senate.]

* * *

Congress of the United States
House of Representatives
Washington, D. C.

October 22, 1943.

Dr. Karl L. Schaupp, President
California Medical Profession

My dear Doctor Schaupp:

Receipt is acknowledged of Doctor Kress' letter of October 18, quoting proposed amendment to Public Law 45 covering agricultural workers.

I presume this proposed amendment has been submitted to the Chairman of the House Committee on Appropriations, from which Committee the original law was reported. I shall be very glad to give this bill my own personal consideration if and when it comes before the House for action.

Very sincerely yours,
(Signed) Richard J. Welch.
[Member of Congress, 5th District, California.]

* * *

Congress of the United States
House of Representatives
Washington, D. C.

Dear Doctor Schaupp:

This will acknowledge receipt of your letter of October 18, suggesting a revision of Public Law 45.

This appears to me to be a very reasonable proposal, and I assure you the matter will receive my careful consideration.

Sincerely yours,
(Signed) Leroy Johnson.
[Member of Congress, 3d District, California.]

* * *

Congress of the United States
House of Representatives
Washington, D. C.

October 22, 1943.

Dear Doctor Kress:

Agricultural Workers' Health and
Medical Association

Your letter of October 18 received, and I shall be pleased to investigate the possibility of amending Public Law 45 as suggested.

As soon as I have further information I shall let you know.

In the meantime, assuring you of my desire to be of service constantly, I am

Cordially,
(Signed) Thomas Rolph.
[Member of Congress, 4th District, California.]

* * *

Congress of the United States
House of Representatives
Washington, D. C.

October 26, 1943.

Dear Doctor Kress:

Thank you for your letter of October 19 about the importance of adding an amendment to Public Law 45 so as to make it possible for the California Medical Association to carry on the excellent work that has been done among agricultural workers in recent years.

I certainly do not see any reason why there should be discrimination in favor of people especially brought in from Mexico over our own people who have been here for a long time.

Sincerely yours,
(Signed) Jerry Voorhis.
[Member of Congress, 12th District, California.]

* * *

Congress of the United States
House of Representatives
Washington, D. C.

October 27, 1943.

Karl L. Schaupp, M. D., President
California Medical Association

Dear Doctor Schaupp:

The letter of October 18, 1943, from your secretary in regard to a proposed amendment to Public Law 45, Section 3 (a) (2) has been received and carefully noted. The proposed amendment appears to me to have merit and I can see no reason for not giving it my support. It would appear that the classifications in the law should not be discriminatory, but should cover all persons within a general classification.

Very sincerely yours,
(Signed) Clair Engle.
[Member of Congress, 2nd District, California.]

(copy)

Congress of the United States
House of Representatives
Washington, D. C.

October 29, 1943.

Dr. George H. Kress, Secretary
The Council of the California
Medical Association

Dear Doctor Kress:

Referring to your letter of the 18th, regarding the proposed amendment to Public Law 45, Section 3 (a) (2), may I say that I think this is a very meritorious amendment and I will support the same.

With all good wishes, I am

Sincerely yours,
(Signed) John H. Tolan,
[Member of Congress, 7th District of California.]

Orthostatic Albuminuria.—Before a diagnosis of orthostatic albuminuria is made, the following criteria should be met: (1) No past history of renal disease; (2) normal blood chemistry, nonprotein nitrogen, blood urea, total protein and albumin-globulin ration; (3) normal kidney function (phthalein, urea clearance, and dilution and concentration tests); (4) no white blood cells, red blood cells or casts in the urine, except intermittently and in small numbers; (5) no elevation of blood pressure; (6) negative plain x-ray pictures and intravenous urograms; (7) absence of albumin in the urine voided when in the recumbent position.—H. H. Young et al., Baltimore, in *Military Surgeon,* April.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

San Francisco Hospitals Accept the Nurses' Association Plan

San Francisco's registered nurses, their forces vastly decreased because of wartime demands, have developed a plan to give the maximum of nursing service to the greatest number of hospital patients.

The plan, to go into effect in twelve of the city's thirteen hospitals on Monday, was presented to and accepted by hospital administrators yesterday.

Under the plan, prepared by the San Francisco County Nurses' Association, private duty nurses will be called to do staff replacement on a basis of alphabetical sequence, working straight eight-hour shifts as often as needed.

Hospital administrators have agreed to use the part-time services of those private duty nurses who are unable to function on a full-time basis. They also have agreed to stimulate the use of divisional nursing and, in turn, the city's nurses have agreed to sign for at least three hospitals for periods of staff replacements.

Objectives

Objectives of the staff replacement plan are to supplement the nursing service so that the staff nurse may be protected from too heavy a case load; to assure the hospital and the community of the earnest desire of private duty nurses to make their contribution to the maintenance of essential hospital service during this period of war emergency; to insure the existence of the private duty nursing system and, finally, to assure the maintenance of a form of employment for registered nurses who are unable to engage in full-time general staff nursing. . . .—San Francisco *Chronicle*, October 27.

Nursing Plan to Be Tried for Three Months*

Stanford Hospital yesterday accepted, on three months' trial, the County Nurses' Association plan under which private duty nurses will be routed through tours of duty as general nurses in all San Francisco hospitals.

Following a meeting of the governing committee of the hospital, Dr. Anthony J. J. Rourke made public a letter addressed to the private nurses at Stanford, who protested the hospital's plan to discontinue private nursing, transferring private nurses to general duty.

The letter informed the private nurses that action on the "Stanford" plan will be postponed until February 1, 1941, to give a *"fair trial"* to the nurses' proposal.

It was announced Tuesday that the twelve other hospitals in the city had agreed to the Nurses' Association proposal which is aimed at supplementing nursing service in all hospitals to relieve the pressure on general duty nurses.—San Francisco *Examiner*, October 28.

Nurses Needed by the Army

The number of nurses required by the Army is in direct ratio to its numerical strength, based on exhaustive studies of actual bed requirements for battle casualties in former wars, and the health reports for the Army as a whole over a period of years. One nurse to each ten beds is authorized, but this number provides for all assignments, such as administrative, supervisory, teaching and professional, where bed credits do not exist, such as hospital trains and ships, air evacuation units and general dispensaries. Our present strength is 3,000 below our quota. Nevertheless, up to this time we have been able to meet our needs for two reasons:

1. We have had an unusually low incidence of illness in our training camps in the continental United States.
2. We had comparatively few battle casualties prior to the North African invasion and since then, fewer than had been contemplated.

From this time forward, however, we must be prepared to care for ever-increasing numbers of patients, both at home and abroad and returning from overseas.

Our quota of nurses for the fiscal year ending June 30, 1944, calls for over 51,000 nurses. To attain this objective we will have to procure 23,000 during the next ten months. Of this number, 95 per cent may be nurses who have had little or no postgraduate experience, provided they are basically well trained, but the other 5 per cent must be qualified to fill administrative, supervisory, and teaching positions.

On September 1, 1940, there were 976 nurses in the Corps, 208 of whom had had less than two years of service. One hundred thirty-one of this number were assigned to overseas service. There were fifty-four stations to which nurses were assigned, and there were few hospitals having more than 250 beds and only two having more than a thousand beds.

On September 1, 1943, in comparison, there were approximately 32,000 nurses assigned to more than 1,125 hospitals, ranging in size from 25 to over 3,000 beds. The Army is fortunate in having in the service at this time approximately 450 nurses well qualified to organize the nursing service of the hospitals under construction in the United States and for additional units for overseas service. Replacements will be required for the positions made vacant by such transfers, and it is estimated that 450 will be needed for these assignments and, in addition, we will need an extra 700 for supervisory and teaching positions for these hospitals.

The Hospital Division of the Army is planning to activate over 400 more hospital units before June, 1944, and this will necessitate more nurses well qualified to fill administrative, supervisory, and teaching positions.

Red Cross Volunteer Nurse's Aides have served in seventy-six Army hospitals since January of this year, and at present are serving in thirty-two. Five hospitals are conducting classes for additional aides, who will, on completion of their training, be available for assignment in those hospitals.—*Excerpts from a report presented by Colonel Florence A. Blanchfield, Army of the United States.*

American Red Cross Needs 791,000 Persons for Home Nursing

A program to enroll 791,000 persons in Red Cross Home Nursing classes during the coming year has been endorsed by leading Government experts at the annual fall meeting of the National Council on Red Cross Home Nursing.

This quota for 1943-44 is part of an ultimate national goal of 3,000,000. This is approximately 10 per cent of the women in the country between the ages of 15 and 59, who normally care for the sick at home, exclusive of those who already have had training as graduate nurses, Volunteer Nurse's Aides, and home-nursing students.

With 2,500 nurses needed each month for service in the armed forces, it is evident that no one can have the luxury of private-duty nurses.

In an annual report, Miss Olivia Peterson, in charge of Red Cross Home Nursing for the national organization, said that 533,483 persons completed the course in home nursing from July, 1942 to July, 1943, an increase of 137,269 over last year. Of this number, 80,592 were in school classes, the remainder in community classes of which 28.2 per cent were rural, and 71.8 per cent urban.

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* For editorial comment, see pages 256-257.

COUNTY SOCIETIES[†]

CHANGES IN MEMBERSHIP

New Members (84)

Butte-Glenn County (1)

Caffaratti, Darius F., *Oroville*

Los Angeles County (52)

Aiken, William P., *Wilmington*
Ambler, A. Carleton, *Arcadia*
Bercovitz, Nathaniel, *Pasadena*
Bonynge, Thomas William, *Los Angeles*
Brodersen, H. N., *Los Angeles*
Cefalu, Victor, *Santa Monica*
Cleland, Robert S., *Los Angeles*
Crosby, Benjamin L., *Burbank*
Curtin, Edward D., *San Bernardino*
Duncan, Ray H., *South Gate*
Edelstein, Jacob A., *Los Angeles*
Edwards, Edward G., *Beverly Hills*
Fairchild, Nora M., *Los Angeles*
Falk, Rollin Merton, *Burbank*
Feder, Bernard H., *Los Angeles*
Finkelstein, Gertrude P., *Los Angeles*
Fischer, Peter N., *Sherman Oaks*
Fisher, Russell V., *Long Beach*
Gilbert, Alfred E., *Los Angeles*
Goldberg, Louis, *Los Angeles*
Gregory, Dewey Quintin, *Pasadena*
Grimm, John Elson, *Santa Monica*
Harrington, Kathleen R., *Los Angeles*
Hixson, A. H., *Hawthorne*
Horn, Paula Marie, *Los Angeles*
Janes, Dalziel O., *Long Beach*
Jorgensen, Gilbert Martin, *Los Angeles*
Joseph, Louis D., *Los Angeles*
Kahlstrom, Sylvia Shafer, *Long Beach*
Knox, John F., *Glendale*
Kugel, Arthur Irwin, *Los Angeles*
Lawrence, Lucy Katherine, *Montebello*
Manchester, Raymond D., *Camp White, Oregon*
Melinkoff, Eugene Borice, *Los Angeles*
Monaco, Louis, *Los Angeles*
Moss, Myer N., *Los Angeles*
Nethery, Winston G., *Los Angeles*
Phillips, Edward, *Los Angeles*
Prince, Charles Calvin, *Long Beach*
Prince, Dorothy Dunscomb, *Long Beach*
Robertson, Murl John, *Santa Monica*
Robinson, Emery Irvin, *Los Angeles*
Ryan, Clarence J., *San Pedro*
Sharpe, John Charles, *Los Angeles*
Sirmay, Elizabeth A., *Los Angeles*
Skinner, W. Clifford, *Van Nuys*
Szekely, Joseph L., *Los Angeles*
Tuta, Joseph A., *Long Beach*
Valensi, Albert, *Los Angeles*
Ward, Alsie Gray, *Huntington Park*
Wilkinson, Mary N., *Huntington Park*
Ziskoven, Hedwig Maria, *Los Angeles*

San Bernardino County (1)

Specht, Norman W., *Loma Linda*

San Diego County (3)

Macnamara, George A., *National City*
McBride, J. P., *San Diego*
Obrock, F. A., *San Diego*

San Francisco County (17)

Bonfilio, Marie DeCola, *San Francisco*
Dolman, Percival, *San Francisco*
Fesca, Helmut William, *San Francisco*
Gardner, Alfred E., *Ignacio*
Golman, Mervin Jack, *Fort Baker*
Greenberg, Jacob, *San Francisco*
Horn, Carl E., *San Francisco*
Hyde, Clarence E., *San Francisco*
Iseminger, Sidney Wells, *Sacramento*
King, Gordon Grant, *San Francisco*
Koch, Pearl Elizabeth, *San Francisco*
Marsh, Earle M., *San Francisco*
Moon, Henry D., *San Francisco*
Schmutz, Melvin A., *San Francisco*
Shenson, Ben, *San Francisco*
Silvani, Henry, *San Francisco*
Taylor, Charles E., *San Francisco*

Santa Barbara County (4)

Benning, Henry M., *Santa Barbara*
Carswell, John A., *Santa Barbara*
Jackson, Gustave B., *Santa Barbara*
Mulholland, Stanley C., *Santa Barbara*

Santa Clara County (1)

Giannini, Albert P., *Salinas*

Sonoma County (4)

Barnet, Garfield Stephen, *Santa Rosa*
Johnson, Paul A., *Santa Rosa*
Libby, John Elden, *Santa Rosa*
Miller, Arthur Campbell, *Santa Rosa*

Tulare County (1)

Malcolm, James C., *Visalia*

Transfers (2)

Elsbach, Kurt Joe, from San Francisco County to Los Angeles County.

Mollath, August, from San Diego County to Santa Barbara County.

Retired Members (2)

Chipman, Ernest D., *San Francisco*
Rothwell, William T., *Los Angeles*

In Memoriam

Baxter, Clarence Pennell. (Lieut. Col., U. S. A.) Died in Panama, April 27, 1943, while on active duty, age 52. Graduate of Tufts College Medical School, Boston, 1914. Licensed in California in 1923. Doctor Baxter was a member of the San Diego County Medical Association, the California Medical Association, and the American Medical Association.

✠

Chase, Albert Emery. Died at Santa Ana, September 15, 1943, age 63. Graduate of the Keokuk Medical College, College of Physicians and Surgeons, Iowa, 1907. Licensed in California in 1923. Doctor Chase was a member of the Orange County Medical Association, the California Medical Association, and the American Medical Association.

✠

French, John Rollin. Died at Los Angeles, September 28, 1943, age 63. Graduate of the University of Southern California School of Medicine, Los Angeles, 1906. Licensed in California in 1908. Doctor French was a retired member of the Los Angeles County Medical Association and the California Medical Association.

[†] For roster of officers of component county medical societies, see page 4 in front advertising section.

✢

Green, Leonard Harry. Died at Los Angeles, September 26, 1943, age 46. Graduate of the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1922. Licensed in California in 1923. Doctor Green was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✢

Hamlin, Oliver Deveta. Died at Oakland, October 11, 1943, age 73. Graduate of the Cooper Medical College, San Francisco, 1894. Licensed in California in 1895. Doctor Hamlin was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✢

Miller, Joseph Edward. Died at Los Angeles, September 13, 1943, age 54. Graduate of the Wisconsin College of Physicians and Surgeons, Milwaukee, 1912. Licensed in California in 1923. Doctor Miller was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✢

O'Flaherty, Aloysius E. Died at Santa Monica, October 7, 1943, age 72. Graduate of the Kansas City Medical College, Missouri, 1898. Licensed in California in 1922. Doctor O'Flaherty was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✢

Pursell, Francis John. Died at Los Angeles, September 16, 1943, age 74. Graduate of the Long Island College of Medicine, Brooklyn, New York, 1899. Licensed in California in 1901. Doctor Pursell was a retired member of the Los Angeles County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✢

Quinn, William. Died at San Francisco, May 25, 1943, age 69. Graduate of the Cooper Medical College, San Francisco, 1905. Licensed in California in 1905. Doctor Quinn was a retired member of the San Francisco County Medical Society, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✢

Rakitin, Sergius S. Died at San Francisco, September 4, 1943, age 66. Graduate of the Military Medical Academy, Leningrad, R.S.F.S.R., 1909. Licensed in California in 1925. Doctor Rakitin was a member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

✢

Stafford, David Emmet. Died at San Francisco, September 25, 1943, age 65. Graduate of the University of California Medical School, Berkeley and San Francisco, 1903. Licensed in California in 1903. Doctor Stafford was a member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

✢

Thompson, Clarence Victor. Died at San Mateo, September 13, 1943, age 62. Graduate of the Cooper Medical College, San Francisco, 1903. Licensed in California in 1904. Doctor Thompson was a member of the San Mateo County Medical Society, the California Medical Association, and the American Medical Association.

Young, John Henry. Died at Lemon Grove, October 14, 1943, age 70. Graduate of the Ohio Medical University, Columbus, 1900. Licensed in California in 1900. Doctor Young was a member of the San Diego County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (September, 1943)		50,100
Rural Health Program		5,000
War Housing Projects (approximate)		28,822
Marin	6,000	
Los Angeles	6,500	
San Diego	......	
Vallejo	14,622	
San Francisco	1,700	
Total		83,922

Enrollment of families in the modified plan for War Housing Projects was begun on October 1. Sufficient interest is being shown by the tenants in practically all areas to suggest that an adequate enrollment will be secured to continue with prepaid medicine in these projects.

The commercial program is beginning to show continuous progress in increasing the numbers of new beneficiary members. Most of the recent additions have been made on the surgical contract.

The rural health program has now small units covering some nineteen counties, and is a starting nucleus for further development in these programs which are covering the great majority of the agricultural areas in the State.

* * *

Re: *Commercial Program*

Professional Members of
California Physicians' Service,
Addressed.

A recent survey of the California Physicians' Service professional members in Southern California shows that well over 80 per cent are convinced that California Physicians' Service holds the answer to prepaid medical care and are willing to support the program. A similar survey is being taken on a county basis in Northern California and, to date, returns indicate the same spirit of coöperation that exists in the South.

We realize that the shortage of physicians in California places a considerable amount of additional work on the doctors in private practice. Because of this fact, California Physicians' Service is offering only surgical coverage to new groups.

Financial operations for the commercial program during the month of July were as follows:

Membership dues	$60,400.15
Professional member registration fees	60.00
	60,460.15
Administrative costs	15,710,34
	44,749.81

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† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 5, bottom left-hand column.

Hospital and laboratory	4,927.62
Available for medical service	39,822.19
22,753.5 units of service at $1.75	39,818.63
Transferred to Unit Stabilization Fund	3.56
Previous balance of Fund	39,295.44
Present balance of Unit Stabilization Fund	$39,299.00

A. E. Larsen, M. D.,
Executive Medical Director.

September 23, 1943.

ITEM XXXVII

Resolutions[*] Adopted at Conference of Representatives of Constituent State Medical Associations of Five Pacific States: Washington, Oregon, California, Idaho, and Arizona

Conference in Session in San Francisco, California, on Tuesday and Wednesday, November 2 and 3, 1943

The enactment by Congress of legislation providing funds to pay the cost of securing adequate maternity and pediatric attentions for the wives and children of enlisted men of the lowest four grades is an extension, as a wartime measure, of social security principles with which we, as practicing physicians, are in entire accord. It is our earnest desire to aid in every way possible the application of these services with fairness to the hospitals and to physicians who furnish the actual care, to the Congress of the people of the United States which provides the necessary funds, and especially to the wives and children who need and are entitled to receive these benefits.

We, therefore, representing the State Societies of Arizona, California, Idaho, Oregon, and Washington, in session in San Francisco, California, on Tuesday and Wednesday, November 2 and 3, 1943, propose the following resolutions as the expression of our deliberations.

Resolved, That this preliminary meeting serve as the basis for the formation of a permanent committee which shall be made up of the representatives of the Maternal and Child Welfare Committees of the respective states, chairmen preferred. This committee shall have one regular annual meeting, to be called approximately six weeks prior to the meeting of the House of Delegates of the American Medical Association, and to be called for special session at the request of representatives of any two states, for the purpose of discussion and solution of the various obstetrical and pediatric problems which may arise under this Act of Congress; and be it further

Resolved, That the Maternal and Child Welfare Committees in the various states be given authority to act in this matter by the governing boards of their respective State Medical Associations.

We, the representatives of the State Medical Societies of Arizona, California, Idaho, Oregon, and Washington, therefore propose to our respective societies the following resolutions:

Whereas, It is the intent of Congress that adequate maternity and pediatric services be made available to the wives and children of enlisted men of the four lowest grades; and

Whereas, The regulations now placed upon those directly concerned by this legislation put additional burdens upon coöperating hospitals and physicians, without any benefits to the patients; and

Whereas, The consummation of the intent of Congress is dependent upon the services of the rank and file of licensed practitioners and hospitals, who were not consulted in the planning of this program; and

Whereas, Under the present plan the usual and personal relationship between patient and physician is largely destroyed by the interposition of an agency with regulatory powers; and

Whereas, Physicians generally are willing and anxious that these women and children receive the best possible care; and

Whereas, There already exists in the Bureau of Allotments ample facilities for the disbursement to dependents of such funds as Congress may allocate therefore, we respectfully suggest that the proposed program can be more easily and economically administered directly through the Bureau of Allotments; and, therefore, we hereby suggest that the Bureau of Allotments shall, upon receipt of an affidavit signed by any individual licensed to sign birth and death certificates in the state in which he resides certifying that an enlisted man's wife is within two months of her estimated date of confinement, forward to the wife such monies as Congress may decide necessary to cover medical, hospital and nursing attentions during pregnancy and delivery; and be it further suggested that a similar method of furnishing an affidavit be adopted in disbursing funds to meet the costs of attention to the children of enlisted men of the grades specified; and be it

Resolved, That each state take definite action in conjunction with all other states in accord with these resolutions, to acquaint the congressional representatives of these states with the full intent of these resolutions; and be it further

Resolved, That copies of these resolutions be sent:

1. To the officers of the State Societies of the eleven (11) Western States; and
2. To the officers of the State Societies of such other states as may appear interested.

Gordon Thompson, M. D., Washington.
O. E. Utzinger, M. D., Arizona
H. E. Dedman, M. D., Idaho
Leslie Kent, M. D., Oregon
W. B. Thompson, M. D., California

Attest:
H. H. Skinner, M. D., Washington,
Conference Chairman.
George H. Kress,
Conference Secretary.

MEDICAL EPONYM

Felty's Syndrome

Augustus Roi Felty (b. 1895), when a junior member of the staff of the Johns Hopkins Hospital, was the author of a paper, "Chronic Arthritis in the Adult Associated with Splenomegaly and Leucopenia," in the *Bulletin of the Johns Hopkins Hospital* (35:16-20, 1924):

The syndrome occurred in individuals of middle age (45 to 65), the average being 50 years. All the patients gave a history of marked loss of weight since the onset of symptoms. . . . The arthritic process is distinctly chronic. . . . The objective findings, both by physical examination and roentgenographic study, are neither widespread nor indicative of a very damaging or destructive process. . . . In every case the spleen was palpably enlarged . . . firm but not tender. . . . In every instance there was noted a yellowish-brown pigmentation of the skin. . . .

In all cases save one, there was a slight secondary anemia. . . . Most striking was the leukopenia, which was a distinctive feature in every case. The leukocyte counts varied from 1,000 to 4,200. . . .

The etiology is entirely obscure, though the various findings seem best accounted for as manifestations of a single disease process.—R. W. B., in *New England Journal of Medicine.*

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[*] Note.—These resolutions were not received in time for placement with other items. See pages 282-284. Also, page 254.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings[†]

California Medical Association. Meetings will convene in San Francisco. Date of the seventy-third annual session, to be held in 1944, to be announced later.

* * *

American Medical Association. Sessions will be held in Chicago (not St. Louis) on June 12-16, 1944. (See *The Journal of the American Medical Association,* November 6, 1943, page 644.)

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and the Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts[*]

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 11:45 a. m., under the title, "Your Doctor and You."

In November, KFAC will present these broadcasts on the following Saturdays: November 6, 13, 20 and 27.

The Saturday broadcasts of KECA are given at 11:15 a. m., under the title, "The Road of Health."

Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association, in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy, are on the air each Saturday at 2 p. m., Pacific War Time.

Pharmacological Items of Potential Interest to Clinicians[*]:

1. *Henry Schuman Hits the Bull's-Eye:* With Harvey Cushing's *Bio-bibliography of Andreas Vesalius,* prefaced by John Fulton, having 83 illustrations, costing $15; John Fulton's description of the *Harvey Cushing Collection of Books and Mss.,* at $8.50; G. Rosen's *History of Miner's Diseases,* prefaced by Henry Sigerist, costing $8.50; and Henry Sigerist's translation of *Arnold of Villanova's Treatise on Wine,* costing $10.

2. *More books:* Eliel Saarinen's *The City: Its Growth, Its Decay, Its Future* (Reinhold, New York, 1943) skillfully compares a city to the growth of any organism, which, if uncontrolled, gets cancerous and centrally necrotic. P. de Kruif's *Kaiser Wakes the Doctors* (Harcourt, Brace, New York, 1943) may be overenthusiastic, but it is interesting. Oxford announces Second Edition of John Fulton's *Physiology of the Nervous System* ($9). Sure to be good is E. V. Cowdry's *Microscopic Technique in Biology and Medicine,* and W. Truslow's *Body Poise* (Williams & Wilkins, Baltimore). Princeton Press offers C. E. A. Winslow's *Conquest of Epidemic Diseases: A Chapter in the History of Ideas.* The Office of Scientific Research and Development will send mimeo of R. A. Phillips, D. D. Van Slyke & Co.'s *Copper Sulfate Method of Measuring Specific Gravities of Whole Blood and Plasma.* Winthrop Chemical Co. will send bibliography on penicillin.

3. *Endocrines:* F. L. Dey (Endocrin., 33:75, 1943) notes that hypothalmic lesions prevent hypophyseal secretion of luteinizing hormone, resulting in genital hypertrophy. K. J. Karnaky *(Jour. Clin. Endocrin.,* 3:413, 1943) finds hexestrol less toxic but less potent than diethylstilbestrol, while J. G. Crotty & Co. *(Surg., Gyn., Obs.,* 77:130, 1943) think hexestrol is best for estrogenic therapy. More evidence supporting treatment of tumors by estrogens is given by W. M. Biden *(Brit. Med. Jour.,* 2:57, 1943) and G. H. Duncan, *(Ibid.* p. 137). K. N. Krishman finds that anterior pituitary extract (Antuitrin-G) promotes calcium retention *(Indian Jour. Med. Res.,* 30:589, 1942). H. E. MacDermott describes fine McGill mural on endocrines by Marian Scott,—like Homer Wheelon's *(Canad. Med. Assn. Jour.,* 47:224, 1943).

4. *Chemotherapy:* H. L. Chung and H. K. Chow *(Chinese Med. Jour.,* 61:71, 1942) find new sodium salt of mannite antimonic acid very effective in experimental kala-azar, but with some kidney and liver injury. The *Chinese Med. Jour.* now is published from Washington, D. C. A. I. Permer and A. I. Bernheim *(Gastroenterol.,* 1:765, 1943) note that ergotamine tartrate inhibits hemoconcentration and anatomical lesions in alimentary tract due to Shiga toxin. Q. B. Lee *(Texas State Jour. Med.,* 39:175, 1943) finds sulfanilamide locally significantly reduces mortality and morbidity in appendicitis. H. E. Carter and S. R. Dickman find anomalous amino nitrogen values in penicillin, suggesting caution; doubt presence of free primary amino group in penicillin *(Jour. Biol. Chem.,* 149:571, 1943). Another question,—does penicillin contain sulfur? Funny if it were to be relatively simple "enzyme" or "vitamin" competitor. F. Bernheim and H. I. Kohn *(Science,* 98:223, September 3, 1943) show propamidine (4:4 diamidinodiphenoxy propane) to be more powerful bacterial inhibitor

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[†] In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

[*] County societies giving medical broadcasts are requested to send information as soon as arranged.

[*] These items submitted by Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

than stilbamidine and to act by inhibiting cellular oxidative metabolism.

5. *Etc.:* J. P. Muzzo *(Rev. Med. Exp.,* Lima, 2:25, 1943) finds overproduction of fibrinogen in anemias of interesting Carrion's disease (C. Howe, *Arch. Int. Med.,* 72:147, 1943; *Sci. Month.,* August, 1943). L. Pauling & Co. *(Science,* 98:263, September 17, 1943) confirm J. R. Marrack's framework of lattice theory of serological precipitation and agglutination *(Chemistry of Antigens and Antibodies,* Med. Res. Counc., London, Report No. 230, 1938). J. H. Quastel offers neat survey of enzymes and their mode of action *(Endeavor,* 2:85, 1943). A. Weil *(Growth,* 7:257, 1943) finds male rat brain matures chemically earlier than female—with aging there is increase of lecithins, galactolipids and sphyngomyelins at the expense of cephalin. W. Blackwood and H. Russell (*Edin. Med. Jour.,* 50:385, 1943) find prolonged nerve muscle injury in experimental immersion foot. Thorough study of toxicity of tannic acid by G. R. Cameron & Co. in *Lancet* (August 14, p. 179, and August 21, p. 218, 222, 1943).

New Chemicals Now Used on Wounds.—Radical revision in the treatment of wounds has taken place since the introduction of the new chemical therapeutic agents, the sulfonamids, peroxides, and chlorine-producing substances, according to Dr. T. Eric Reynolds, lecturer in pharmacology in the Medical School of the University of California, now on military leave. Especially is this true in regard to the lapsed-time factor; doctors can now safely undertake procedures on wounds much later than was formerly thought possible.

It seems probable that the mode of action of the sulfonamide group is to render the various body tissue fluids unfavorable as a medium for growth and multiplication of susceptible bacteria. After continued use, the chemical may also inhibit cellular growth, but this can be overcome by the application of several substances among which is cod liver oil.

The peroxides, especially the ones which give off oxygen slowly and continuously, are finding new and wide application in wound surgery. Both zinc and benzoyl peroxide can be used in combination with the sulfonamides.

The chlorine-delivering chemicals now used are a development of the tedious Dakin treatments employed in the last war. They offer a readily available means of keeping down wound infection by the liberation of chlorine.

San Francisco County Medical Society Telephone Service.—Nearly 2,500 persons, mostly newcomers to San Francisco, engaged physicians during the past three months through the San Francisco County Medical Society's "around-the-clock" telephone service bureau (WAlnut 6100).

Calls for assistance in engaging a physician received at County Society headquarters, 2180 Washington Street, during daytime hours totaled 455 in June, 440 in July, and 460 in August.

Night time calls for assistance were at approximately the same level in June and July, with 431 and 424 calls, respectively, but such calls fell off sharply in August, for some unexplained reason, with 227 night calls recorded during the month.

The Society established the telephone bureau last year as a public service especially for newcomers to the city and for oldtime residents whose doctors had departed for the war. The Society's membership was first polled to locate physicians who could take additional patients, and doctors who could take night calls.

California Tuberculosis Association: Christmas Seals.—With its customary double-barred cross in the lower lefthand corner, the 1943 Christmas Seal will arrive in homes throughout the country as the mail sale opens November 22.

Although the thought may not have occurred when the double-barred cross was selected as the emblem of the organized fight against tuberculosis more than forty years ago, its two arms joined together in a common cause have proved symbolical of the harmonious relationship between physicians and laymen in the battle aimed at the control of this disease.

The first sanatorium in America was founded by a physician who was later to become the first president of the National Tuberculosis Association. But even before the founding of this organization, members of the Southern California Medical Society were establishing a society to fight tuberculosis.

This new organization, started in 1902, grew to include laymen and, after several changes in name and constitution, finally emerged as the California Tuberculosis Association as it is known today. During the 30's, relationships between the Association and the physician in private practice were welded together to a point where every county medical society in California was lending its active support.

California Trudeau Society.—In 1940 it obtained a charter from the American Trudeau Society and, in a matter of months, became recognized as one of the leading organizations of its kind in the United States. Both through the Trudeau Society and the Association, numerous services have been made available to the private practitioner in California. The physician, meanwhile, has been contributing more than his part by his public and private endorsement of the Association and its work.

For the past two years CALIFORNIA AND WESTERN MEDICINE has published a section devoted to the papers presented at the annual meeting of the California Tuberculosis Association and the California Trudeau Society. The section later has been made available as a reprint.

Morris Herzstein Lectures at Stanford.—Dr. Oscar Ivanissevich, professor of surgery and director of the Surgical Institute at the University of Buenos Aires, will give the Morris Herzstein Medical Lectures for 1943 in San Francisco on November 15, 17, and 19.

Doctor Ivanissevich, who has an international reputation in plastic and reconstruction surgery, is exchange professor of surgery at the Stanford School of Medicine for the months of October and November.

The lectures will be given at 8 p. m. at the San Francisco County Medical Society, 2180 Washington Street. Titles will be:

November 15—*General Consideration of Echinococcosis.*
November 17—*Echinococcosis of the Liver.*
November 19—*Echinococcosis of the Lung.*

The Herzstein lectures were established in 1929 by the late Dr. Morris Herzstein of San Francisco, to be given under the direction of the medical schools of Stanford University and the University of California. They are given on alternate years by scientific men of outstanding achievement and are open to the public as well as to the medical profession.

Casualty Statistics of World Wars I and II.—A tremendously heartening report on one phase of war's grimmest subject, the casualties of combat, is contained in a current American magazine article by Rear Admiral Ross T. McIntire, Surgeon-General of the Navy and personal physician to President Roosevelt.

Reporting on the almost unbelievable success of modern methods of treating both battle wounds and disease, Admiral McIntire reveals some new facts that should allay a good many of the fears of worried parents. For instance:

In the last war, 7 per cent of the men wounded in action died; this time, 2 per cent.

Last time, 20 per cent of all abdominal wounds proved fatal; this time, 5 per cent.

Last time, nearly half the compound fracture cases were permanently crippled and 12 per cent died; this time, not more than one per cent will die, only 10 per cent will be disabled, and there will be "very few" amputations.

In 1918, the Navy death rate for all diseases was 1179.66 per 100,000 men; today it is only 65.34 per 100,000.

Of 4,039 casualties (Army, Navy, and Marine) treated on one hospital ship in the south Pacific, only seven men have died.

All this, says the Admiral, is "unprecedented in the history of warfare."

"The record," he points out, "is one that gives a sense of security to any fighting man, and one that gives hope to civilians after the war, particularly those injured in industrial and motor-car accidents."

Credit for the drastic reduction in deaths, both from wounds and diseases, is awarded by Admiral McIntire to three main innovations of this war, in addition to the general improvement in medical techniques. These are blood plasma, two new drugs (the sulfa group and penicillin), and speed.

Isolation Unit Sought for Los Angeles County Hospital.—Prompt action in setting up facilities for proper isolation of smallpox cases was recently urged upon the Los Angeles Board of Supervisors by County Superintendent of Charities Arthur J. Will.

Since the discontinuance of the Los Angeles Isolation Hospital, also known as the pest house, in 1938, Will said there "has been no provision made either in the city or the county to meet the eventuality of a smallpox epidemic."

"Should it become necessary to admit even one smallpox patient to the communicable disease unit of the General Hospital, it would be necessary to vaccinate all patients and personnel," he said.

"Such a program of vaccination would not absolutely guarantee against the spread of the disease which might be carried to other units of the hospital."

Will said that when an epidemic occurs, it would be impossible to admit such patients without serious consequences to other patients and to the employees of the institution.

American Board of Obstetrics and Gynecology.—The next written examination and review of case histories (Part I) for candidates will be held in various cities of the United States and Canada and by special arrangements at Army and Navy stations on Saturday, February 12, 1944, at 2 p. m. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year. All applications for this year's examinations must be in the office of the secretary by November 15, 1943.

The office of the Surgeon-General (U. S. Army) has issued instructions that men in service, eligible for Board examinations, be encouraged to apply and that they may be ordered to detached duty for the purpose of taking these examinations whenever possible. The office of Surgeon-General of the U. S. Navy presumably takes a similar attitude on this matter.

The place of the Board's Part II examination in May or June, 1944, has not yet been decided, but it is likely to be held in that city nearest to the largest group of candidates. The exact time and place will be announced later.

If a candidate in Service finds it impossible to proceed with the examinations of the Board so that his plans are thus interrupted, deferment of parts of these without time penalty will be granted under a waiver of our published regulations covering civilian candidates.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, 6, Pennsylvania.

Medical Information Concerning the War Effort.—The Johnson & Johnson Research Foundation, New Brunswick, New Jersey, through Dr. Ross G. Harrison, chairman of the National Research Council, has announced the acceptance by the National Academy of Science—National Research Council—of a grant from the Johnson & Johnson Research Foundation in the amount of $75,000. The grant was made to enable the Division of Medical Sciences of the Council, under the chairmanship of Dr. Lewis H. Weed, to gather medical information pertaining to the war effort and to disseminate summaries. The program of the Division of Medical Sciences of the National Research Council contemplates coverage of the various medical reports and bulletins which emanate from civilian and military activities throughout the world. The enterprise should fill a much-needed gap in the war effort in medicine; for one of the greatest difficulties encountered in medicine today lies in providing adequate up-to-date information to the medical officers of the armed services, both in this country and abroad, and in making the experience of war medicine available as far as possible to civilian physicians.

The Johnson & Johnson Research Foundation appropriation to the National Research Council becomes immediately available; in accordance with present plans, it will be utilized in the period up to June 30, 1945. A central office will be established in Washington, and reporters will be appointed in various foreign countries so that a staff of special observers abroad will be working under the direction of the central office. The various theaters of operation present medical problems in which climate, season of year, distribution of insects, distribution of disease, all play different rôles. Reports from widely separated parts of the world will be of the greatest medical importance, and it is hoped that, with the combined effort, much of significance will be achieved.

The Johnson & Johnson Research Foundation was established on January 1, 1940, as a nonprofit philanthropic organization by Johnson & Johnson, New Brunswick, New Jersey, with the express purpose of supporting research and development of products to serve the medical profession. It has made appropriations for both fundamental and developmental investigations and is currently sponsoring about one hundred projects located in twenty-eight universities. The fields of medical interest which have largely been supported are pharmacology (including antiseptics), allergy, physiological studies in pediatrics and human fertility.

Hormones and Cancer: Undergraduate Contest.—The third nation-wide competition for the Schering Award is now open. Three major prizes of a total value of $1,000 will be awarded to undergraduate medical students who submit the best critical dissertations on the subject, "Hormones and Cancer." As in previous years, the judges for the Schering Award will include outstanding American investigators in the fields of endocrinology, medicine, and chemistry. For information, communications should be addressed to "The Interne," 7 East Forty-Second Street, New York, 17, N. Y.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Dr. Frank W. Otto Is Named to State Medical Board

Governor Earl Warren today appointed Dr. Frank W. Otto of Los Angeles as a member of the State Board of Medical Examiners, succeeding Dr. Charles B. Pinkham of San Francisco, resigned after thirty years of state service, most of it as secretary-treasurer of the board.

Governor Warren revealed he has had Doctor Pinkham's resignation since February. Doctor Pinkham, withdrawing from the board at the compulsory retirement age of 70 years for salaried officials, said he feels the need of a rest after three decades of work as the executive member of the medical profession's regulatory agency.

Doctor Pinkham Lauded

The governor sent Doctor Pinkham a letter expressing "the gratitude of the people of our state for your long, honorable and distinguished service."

Doctor Otto will serve out Doctor Pinkham's unexpired term, ending January 15, 1944.

State officials announced Dr. Frederick N. Scatena of Sacramento has been acting as secretary-treasurer of the board.

Doctor Otto, 50, was graduated from the University of Southern California Medical School in 1921. He is the senior attending physician of the Los Angeles County General Hospital, a fellow of the American College of Physicians, assistant clinical professor of medicine at the University of Southern California, past president of the university's alumni association and a member of the council of the Los Angeles Medical Association.—*Sacramento Bee*, October 6.

Governor Warren Appoints Dr. Albert S. Chapman to State Medical Board

Sacramento, Oct. 19 (U.P.).—Governor Earl Warren today announced appointment of Dr. Herbert S. Chapman of Stockton to membership on the State Board of Medical Examiners. He replaces Dr. Frederick De Lappe of Modesto, whose term expired.—Los Angeles *Daily News*.

Industrial Medicine Start Credited to Long Beach Physician

Dr. Andrew M. Harvey, assistant city health officer of Long Beach, was described as "the father of industrial medicine in America" in the leading article of the current issue of *Industrial Medicine*. The 125-page magazine is the organ of the American Association of Industrial Physicians and Surgeons.

The Long Beach official is declared to have been "the first medical director of this country," having been appointed to that position by the Crane Company of Chicago in 1896.

Doctor Harvey left his post in 1937 and came to Long Beach to retire. Here he was recalled to active service a year ago by the need of the city health department for a competent executive trained in public health.

First steps to equip industrial workers with protective glasses was taken by Doctor Harvey, who himself was the founder of the American Association of Industrial Physicians and Surgeons, on whose board of directors he served for many years.

Under his leadership and that of his colleagues, Doctor Harvey recalls the successful campaigns waged for factory safety, the elimination of silicosis as an industrial disease and the introduction in factories of salt tablets for workers, to replace salt lost in perspiration.

Rest periods for women, lunch rooms and shower baths were pioneered by Doctor Harvey and others in the association.

Although little progress in controlling the common cold was made, its spread was prevented by insisting that workers afflicted remain off the job so that others would not be contaminated.

For his work in industrial medicine Doctor Harvey was awarded a degree of doctor of science by Knox University at Galesburg, Illinois.—Long Beach *Telegram*, October 6.

Surgeon-General of U. S. Army Visits Palm Springs

Palm Springs entertained distinguished visitors Tuesday when Major-General Norman T. Kirk, surgean-general of the Army, visited Torney General Hospital in the afternoon and was guest of honor at a reception that evening at the Officers' Club. General Kirk is at present on a tour of Southern California medical installations.

Accompanied by Colonel Raymond W. Bliss of the surgeon-general's office, General Kirk arrived at Torney Tuesday afternoon at 2:30, where he was greeted by Colonel A. B. Jones, commanding officer of the local institution, and official party. An inspection of Torney followed.

Tuesday night General Kirk and Colonel Bliss were honored at a reception at the Officers' Club. Officers of Torney General Hospital and their wives and officers of the Twenty-second General Hospital and their wives greeted the distinguished visitors.

Colonel Bliss, who is chief of operations and training of the surgeon-general's office, received notification when in Banning, where the party went after leaving here, that he had been promoted to brigadier-general.

Colonel William B. Shambora, surgeon for the Army ground forces, and Lieutenant-Colonel Harold A. Furlong, surgeon for the Desert Training Center communications zone, accompanied General Kirk on his tour of medical installations.

Interesting Career

General Kirk has had a varied and interesting career in the Army. His first service was at the Soldiers' Home in Washington, D. C., in 1912. Since then he has been assigned to many Army hospitals, including the Walter Reed General Hospital, Washington, D. C. He has completed tours of duty at Johns Hopkins University Hospital in Baltimore and other prominent civilian hospitals. In recognition of General Kirk's service, on May 28, 1943, the Senate of the United States confirmed the President's nomination of him as the surgeon-general of the United States Army.

Noted Authority

General Kirk is recognized as a general surgeon of extremely high capacity, being particularly well known for his work on bone and joint surgery. His volume on "Amputations: operative technique," which appeared in 1924 and which was the result of large experience following World War I, is still a standard textbook. In addition to this book he has written a great many other articles on clinical and operative surgery. General Kirk has been honored by membership in the most selective surgical societies of the United States.—Palm Springs *Desert Sun*, October 8.

Palo Alto Doctor Cited for Service on Guadalcanal

A Palo Alto physician has been awarded the Legion of Merit for exceptionally meritorious service on Guadalcanal, it was announced yesterday by Twelfth Naval District headquarters.

The medical hero is Lieutenant Ferrall H. Moore, 252 Seale Avenue, who, according to his citation, attached to a Marine aircraft wing and was in charge of the evacuation of casualties at Henderson Field, Guadalcanal, from November 30, 1942, to February 4, 1943.

"With outstanding ability Lieutenant Moore reorganized the plan which facilitated the loading and evacuation of patients at the air field," the citation read.—San Francisco *Chronicle*, October 28.

MEDICAL JURISPRUDENCE[†]

HARTLEY F. PEART, ESQ.
San Francisco

Malpractice: Sufficiency of Evidence to Sustain Verdict Against Physician

A California physician and surgeon was named as defendant in a malpractice action to recover damages for alleged disfigurement and permanent deformity resulting from operations performed on the patient's nose. Judgment was rendered for the plaintiff against the defendant physician in the sum of $5,000, and on appeal from this judgment in the action, entitled *Soest* vs. *Balsinger*, 60 A. C. A. 519, the District Court was presented with the question of whether evidence introduced in the trial court was sufficient to sustain the verdict.

The Court ruled on September 13, 1943, that, in a malpractice case, it is not necessary for the plaintiff to demonstrate conclusively and beyond possibility of a doubt that the defendant physician's negligence resulted in the injury to the patient and, further, that the causal connection between the physician's alleged negligent acts or omissions and the alleged damage need not be established with such certainty that any other conclusion is excluded. The judgment in favor of the patient and against the physician was affirmed.

[†] Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

In May of 1940, on advice of two physicians that she needed a submucous resection of the nose in order to relieve severe headaches and difficult breathing, the plaintiff consulted defendant. After examination, defendant operated upon the plaintiff's nose, first applying a local anesthetic, and performed a submucous resection. In addition, he removed a hump on plaintiff's nose and a scar on her forehead. The nose was packed with gauze and, after a week of daily visits to the defendant's office, the packing was removed and infection was discovered.

To relieve the condition resulting from infection, defendant incised both nostrils. In August, defendant performed a second operation on the patient's nose, which was then completely closed because of the infection. Three holes developed in the patient's septum, and in October the plaintiff complained to defendant of these holes, the misshapen rims of the nostrils and other ill-effects of the operations. In November the defendant physician urged plaintiff to submit to a further operation, but she refused owing to her lack of confidence in him. Plaintiff thereupon commenced this action, charging defendant with negligence in the performance of the operation and in her subsequent care. It appeared at the trial that plaintiff's nose was scarred and that there were holes in her septum.

The evidence submitted by plaintiff to support her charge of negligence consisted of testimony of the nurse who assisted at the first operation, to the effect that after the packing was removed the defendant had charged this nurse with a "slip-up" in technique and had blamed her for not sterilizing instruments properly. In addition, plaintiff produced three physicians and surgeons who gave their expert opinions, the first testifying that no surgery should be performed where infection is present (the defendant here had performed a second operation after the discovery of the infection). A second physician testified that he had found three holes in the septum of the plaintiff's nose, and that an attempt had been made to perform a submucous resection to remove a portion of the septum and that the resultant holes in the nose would affect plaintiff's health. He further testified that certain depressions and indentations on plaintiff's nostrils could have been caused by taking away too much tissue in the performance of the operation, and that the correction of the nose would be an extremely difficult thing. The third physician presented by plaintiff testified that perforations in the septum following the submucous resection may be caused "either from perforation of both of layers through and through, perforations at the time of surgery which broke down the circulation and caused the perforation. They may be due to infection either before or after surgery."

On appeal the defendant physician contended that the plaintiff had failed to support her charge of malpractice by sufficient evidence, and cited authorities to the effect that negligence on the part of a physician or surgeon will not be presumed and that it must be affirmatively proved. In the absence of expert evidence it will be presumed that a physician or surgeon exercised the ordinary skill and care required of him in treating his patient.

The Court ruled that the evidence above summarized was ample to support a finding by the jury that the physician did not use that degree of care and skill exercised by physicians in the same locality. Particular emphasis was placed upon the fact that a second operation had been performed after discovery of the infection. Authorities were cited to the effect that the danger of infection from such a field of operation is a matter of common knowledge and that a jury is authorized to draw the reasonable inference of negligence.

LETTERS†

Concerning Botulism Antitoxin: Where Obtainable:

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH

October 6, 1943

To the Editor:

We would appreciate your giving publicity to the enclosed in CALIFORNIA AND WESTERN MEDICINE.

We desire the medical profession to be informed where botulism antitoxin can be obtained.

Very truly yours,

(Signed) MILTON P. DUFFY, *Chief,*
Bureau Cannery Inspection.

* * *

BOTULISM

Keep This for Ready Reference

Cases or suspected cases should be reported at once to the *State Department of Public Health.* All foods suspected of being the source should be held for laboratory examination. Keep opened foods under refrigeration.

Antitoxin for Treatment

Antitoxin for treatment is available and should be administered as soon as botulism is suspected. Antitoxin may be obtained *day* or *night* from the *Lederle Laboratories, Inc.*

Phone direct to: San Francisco—274 Brannan Street, EXbrook 3730, or DOuglas 6500; Los Angeles—643 South Olive Street, TUcker 1127.

To be effective, antitoxin must be administered as soon as possible. Use any facilities you can enlist for rapid transportation.

A case of moderate severity may require several ampules, severe cases more. In instances where the costs cannot be met by the individual or the local department, the *Health Officer* is authorized to provide the antitoxin at the expense of the State Department of Public Health. The State Department of Public Health should be notified at once of any such commitment.

Treatment

Antitoxin, one ampule (10,000 units), should be injected intravenously as soon as possible and repeated every four hours until the toxic condition is alleviated. There is considerable evidence the antitoxin is more effective if combined with 5 per cent glucose solution. Intravenous 5 per cent glucose solution may be started before antitoxin is available. General treatment should include rest in bed, avoidance of fatigue, exclusion of visitors, complete evacuation of the lower intestinal tract unless such procedure is too fatiguing, forcing of fluids. Tube feeding may be required. Suction for removal of salivary secretions frequently is necessary. Keep your *Drinker* respirator in mind. Its use is indicated whenever respiratory depression sets in and when respiratory stimulants and oxygen are ineffective.

Prophylaxis

For those who have eaten the suspected food but have not developed symptoms, 1,000 to 2,500 units intramuscularly. If symptoms develop, treat with full therapeutic doses intravenously.

Caution

This antitoxin is made from horse serum. Test for sensitivity.

—California State Department of Public Health.

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† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Concerning Medical Literature Sent to Military Camps —A Letter of Appreciation:

(COPY)

HEADQUARTERS
OFFICE OF THE SURGEON, STATION DISPENSARY
FORT MASON, CALIFORNIA

October 13, 1943

Dear Doctor Kress:

The copies of the *Journal of American Medical Association and Surgery, Gynecology and Obstetrics* arrived today and, on behalf of the staff stationed here at the Station Dispensary, please accept my sincere thanks for your kindness. The journals will be well utilized and will prove of distinct value at this office.

Again, our thanks.

Very cordially yours,
(Signed) JEAN S. FELTON,
Major, Medical Corps, Surgeon.

Concerning a Legal Opinion on Admission of Patients to County Hospital:

(COPY)

Re: Admission of patients to county hospitals.

L. A. Alesen, M. D.
1401 South Hope Street
Los Angeles, California

Dear Doctor:

Please excuse our delay in sending you an opinion with regard to admission of patients to county hospitals.

We will endeavor to set forth in this letter the California law with regard to this question.

The law covering admission of patients to county hospitals is set forth in *Goodall* vs. *Brite,* 11 Cal. App. (2d) 540, where it was held that county hospitals may admit indigents as patients and may admit so-called "part-pay patients," but may not admit persons financially able to pay the costs of private hospitalization and medical care.

The so-called "part pay" group was defined by the Court to include persons able to pay some portion of the costs of hospitalization and medical care but unable to pay the full cost thereof.

With respect to persons able to pay hospitalization and medical costs, the Court held as follows:

"We, therefore, conclude that the admission and treatment of patients in the county hospital who, either themselves or through legally responsible relatives, can provide themselves with equally efficient care and treatment in private institutions, does not promote the health and general welfare of the citizens of Kern County and is not a proper exercise of the police power of that county and results in the use of public money for private purposes."

The case of *Goodall* vs. *Brite* is the only California decision upon the subject of admission of patients to county hospitals and is determinative of the present California law.

The Court's ruling, however, against the admission of patients to the Kern County Hospital who were financially able to provide equally efficient care and treatment in private hospitals was based, in part, upon the fact that there were adequate private hospital facilities in Kern County. Further, the Court stated that another class of patients which should be admitted to county hospitals were the victims of public disaster, accident, or sudden illness. This type of patient, the Court said, should be admitted promptly and if subsequent investigation disclosed ability to pay for hospitalization the county authorities could then require them to pay in full the cost of care and treatment received.

In view of these statements in the opinion in *Goodall* vs. *Brite,* it is our opinion that, if exigencies created by war conditions rendered private hospital facilities in the county inadequate, so that even persons with ample means were unable to obtain admission to private hospitals or proper care therein, it would be proper to admit them to county hospitals, charging a proper fee. If the county hospital is the only institution where hospitalization can be obtained, then it would promote the general welfare of the county to deviate from the rules set down in the case of *Goodall* vs. *Brite.*

If you have any further questions, please let me know.

Very truly yours,
HARTLEY F. PEART.

P. S.: This opinion is concerned solely with questions of indigency and we have not considered other classes of patients who are entitled to admission to county hospitals, such as criminals, insane persons, or those suffering from contagious diseases. H. F. P.

Concerning Assignment of Hospital Nurses:

(COPY)

ATTENDING MEDICAL STAFF
THE CALIFORNIA HOSPITAL
1414 South Hope Street
Los Angeles

To the Members of the Attending Medical Staff:

The undersigned committee was appointed by the Executive Medical Board to coöperate with federal and state agencies in assisting in the program of providing adequate nursing service in military and civilian service. The Committee has made a study of this problem because of the acute shortage of nurses in our hospital and an analysis of cases in the hospital, and finds the following situation:

First: This hospital, as well as all other hospitals, must coöperate in utilizing the graduate nurses for the most essential nursing services in caring for the ill and injured. Attendants must be trained and used as auxiliary workers taking care of many duties formerly performed by nurses that can and should be performed by attendants.

Second: An investigation has revealed that the medical staff in this hospital is using about as many special duty nurses at the present time as prior to the war emergency. We find that many of these nurses are assigned because of the request of the patient purely from an economic standpoint.

The Committee, therefore, in coöperation with federal and state authorities, seeking to eliminate as much as possible of luxury nursing, requests physicians on the staff of the hospital to only assign special nurses on the basis of medical need. Every morning the Committee will have available from the Director of Nurses' Office a report indicating the special nurse assignments in the hospital, and depending upon the condition of the patient, will give a memorandum to the doctor at various periods requesting him to check the need for continuing the assignment of special nurses.

We, therefore, solicit your consideration of the problem and request your coöperation in trying to assist in the war effort by making more nurses available for essential military and civilian needs.

Very truly yours,

THE COMMITTEE OF THE EXECUTIVE MEDICAL BOARD:
E. J. Cook, M. D., *Chairman.*
George F. Schenck, M. D.
Walter A. Bayley, M. D.
H. D. Van Fleet, M. D.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 11, November, 1918

EXCERPTS FROM EDITORIAL NOTES

Influenza.—Epidemic influenza has reached the Pacific Coast in its pandemic progress from eastern Europe around the world. It is doubtless the same disease which appeared in pandemic form in 1889-1890, and, previous to that, at more or less regular periods for many centuries. Its specific cause is unknown, although the name "influenza bacillus" was attached by Pfeiffer in 1892 to a certain organism found in the nasal and bronchial secretions. This bacillus is found in only a minority of cases in the present epidemic. . . .

Epidemic influenza, to use the Italian term, or la grippe, after the French, is characterized now as previously, by the extraordinary speed of its spread, this being, however, no more rapid than means of human conveyance, and by the high percentage of the population attacked. . . . Previous epidemics have attacked as high as 40 per cent of the population. Thus far, from 10 to 15 per cent of the cases have been complicated with pneumonia, to which most of the fatalities are due. Approximately one-third of the pneumonias prove fatal, although there is reason for believing that this mortality will be lower in California. . . .

The Psychopathic Hospital Idea.—One of the institutions badly needed by California, and especially by the community in and about San Francisco, is a Psychopathic Hospital, and the medical profession as a whole should interest itself in the effort now being made to obtain such. . . .

However, the time has long since passed when it is necessary to enumerate arguments in favor of a Psychopathic Hospital. That one is an absolute necessity, is a truism. At present the only argumeent against its immediate erection is the expense. Surely, a rich, self-conscious State like California will not lag behind and allow this need to continue unmet. The thousands of dollars now spent by courts, social agencies, schools, charitable organizations and hospitals in trying to solve these problems of the psychopathic individuals would more than build and maintain a Psychopathic Hospital.

Newspapers and the Doctor.—How the average newspaper does enjoy poking fun at the doctor! And how often it slurs him and his work, and, by innuendo and unrefuted misstatement, allows him to suffer injustice! Such, doubtless, is to be expected, and as a general thing arouses only amusement at the expense of the newspaper. . . .

The Communal Kitchen.—Pressure of food conditions due to the war has led to widespread employment of communal kitchens in European countries. England has this year established national kitchens, under the Director of the Communal Kitchens Section of the Ministry of Food. Late in March [1918] there were in that country 250 kitchens with the probability that inside of two months the number would increase to 1,000. . . .

Flight Surgeons.—For the care and conditioning of fliers in the air service, the Government is now [1918] appointing

(Continued in Front Advertising Section, on Page 22)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.,
Secretary-Treasurer

Board Proceedings

At the meeting of the Board of Medical Examiners held at 1020 N Street, Sacramento, October 18 to 21, 1943, fifty-two candidates presented themselves for written examination, fifty of whom were physicians and surgeons, one drugless practitioner, and one midwife.

This being the annual meeting of the Board, election of officers was held. The new officers are as follows: Dr. George Thomason of Los Angeles, President; Dr. Alvin E. Cerf of San Francisco, Vice-President; Dr. Frederick N. Scatena of Sacramento, Secretary-Treasurer.

There will be an additional written examination held at Native Sons Hall, San Francisco, November 16 to 18, 1943, as well as an oral examination, which will be held at the Board office, 515 Van Ness Avenue, San Francisco.

Upon petitions for restoration of certificate, the Board acted favorably in the following instances:

Howard Doane Mayers, M. D., on October 19 was placed on probation for a period of five years with specified terms.

Alfred Edward Meyers, M. D., on October 19 was placed on probation for a period of five years with specified terms.

Milton Francis Novotny, M. D., on October 19 was placed on probation for a period of five years with specified terms.

David Andrew Stevens, M. D., on October 19 was placed on probation for a period of five years.

News

"Governor Earl Warren today appointed Dr. Frank W. Otto of Los Angeles as a member of the State Board of Medical Examiners, succeeding Dr. Charles B. Pinkham of San Francisco, resigned after thirty years of State service, most of it as secretary-treasurer of the Board. Governor Warren revealed he has had Dr. Pinkham's resignation since February. Dr. Pinkham, withdrawing from the Board at the compulsory retirement age of 70 years for salaried officials, said he feels the need of a rest after three decades of work as the executive member of the medical profession's regulatory agency. The Governor sent Dr. Pinkham a letter expressing 'the gratitude of the people of our State for your long, honorable and distinguished service.' . . . Dr. Otto, 50, was graduated from the University of Southern California Medical School in 1921. He is the senior attending physician of the Los Angeles County General Hospital, a Fellow of the American College of Physicians, Assistant Clinical Professor of Medicine at the University of Southern California, past president of the university's alumni association, and a member of the Council of the Los Angeles Medical Association. . . ." (Sacramento *Bee,* October 6, 1943.)

"Dr. Ralph C. Lewis, son of Mr. and Mrs. Harry W. Lewis of Santa Ana, medical missionary to China, is expected to be among the exchange prisoners aboard the *Gripsholm* when it returns from its mission of taking 1,300 Japanese nationals back to their homeland, it is disclosed here. . . . Actual exchange of the prisoners, according to word from the State Department to Dr. Lewis' parents, will

(Continued in Back Advertising Section, on Page 34)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

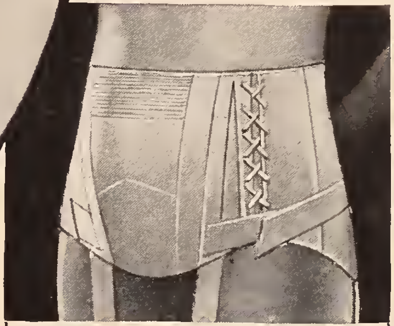
ANATOMY OF PREGNANCY

Four Lunar Months' Pregnancy

One of a series of life-size sculptured models made for S. H. Camp and Company by Charlotte S. Holt.

●

4 Lunar Months — Abdominal protrusion beginning. Uterus becomes abdominal organ. Fundus 4 cm. below umbilicus. Approximate time of quickening. Normal visceral relationship. No appreciable change in body mechanics.



The clinical value of Camp Prenatal Supports and Breast Supports has for many years been recognized as anatomically correct and efficient. They are moderately priced and easily adjusted by the Camp Patented Adjustment feature.

IT is during the fourth month that the patient is usually sent for her support, although a breast support is usually advocated at the beginning of pregnancy.

CAMP

ANATOMICAL SUPPORTS

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S. H. CAMP & COMPANY • Jackson, Michigan
Offices in CHICAGO • NEW YORK • WINDSOR, ONTARIO • LONDON, ENGLAND
World's Largest Manufacturers of Anatomical Supports

STILL THE SAME OLD JOHNNIE WALKER

BORN 1820 . . .
still going strong

Unchanging quality has made Johnnie Walker a well-known character all over America.

Due to British war restrictions, gold foil has been eliminated and other slight changes have been made on the *outside* of the familiar Johnnie Walker bottle—but *inside* good old Johnnie Walker whisky remains unchanged.

RED LABEL
8 YEARS OLD
BLACK LABEL
12 YEARS OLD
Both 86.8 proof

JOHNNIE WALKER
BLENDED SCOTCH WHISKY

CANADA DRY GINGER ALE, INC.
New York, N. Y. • Sole Importer

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(For Mental Illness)
LAS CAMPANAS HOSPITAL
(A General Hospital)
COMPTON, CALIFORNIA
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Helen Rislow Burns, M.D.
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APPROVED BY AMERICAN COLLEGE OF SURGEONS

GOVERNMENT ATTACKS DEAFNESS

Important discoveries make possible the greatest help ever offered the hard of hearing.

Write for New Free Booklet About These Latest Government Findings.

ACOUSTICON INSTITUTE
In All Principal Cities
457 POWELL STREET
SAN FRANCISCO
720-725 FOREMAN BLDG.
LOS ANGELES, CALIF.

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 24)

to another cell, which, through its fibers, produces an action. These reflexes may be simple and take place in the same segment of the cord which receives the sensory impulse, the connection being direct from the sensory to the motor neuron; or they may be complex, the acting efferent neuron being separated widely from the afferent, sensory cell body, and the two being connected by several different neurons. . . .

From an Article on "An Unprecedented Opportunity for Women," by Emma Wheat Gillmore, M.D., Chairman, Committee of Women Physicians, General Medical Board, Council of National Defense.—The same year that gold was discovered in California, a lone pioneer received the first medical diploma which the United States had issued to a woman. Other colleges shortly followed the example of the one which had opened its doors to Elizabeth Blackwell, and today over fifty co-educational medical schools admit women upon the same terms as men.

There are more than 25,000 American physicians in military service at this writing, and the Council of National Defense is undertaking, through the Volunteer Medical Service corps—an organization which has President Wilson's approval—the task of classifying the qualifications of 90,000 more. Of these, about 6,000 are women, less than one-third of whom have registered with the General Medical board. . . .

EXCERPTS FROM COUNTY SOCIETIES. LOS ANGELES COUNTY

Subject: Social Health Insurance

There was a special meeting of the Los Angeles County Branch of the California League for the Conservation of the

(Continued on Page 30)

Always tired

"Always tired" is a common enough complaint, but when accompanied by markedly low resistance to infections, low muscular tone and vascular weakness, by mental apathy and depression, the cause may be adrenal cortical insufficiency.

ADRENAL CORTEX EXTRACT (UPJOHN) offers potent replacement therapy with which to combat this syndrome. So carefully are the active steroids extracted to make this *natural* complex, so pure is the final cortical extract, that there is practically no trace of epinephrine, the hormone of the adrenal medulla.

Upjohn pioneering and research have resulted in the potent, reliable preparation many physicians use when a characteristic "syndrome of lowness" points to adrenal cortical insufficiency.

Adrenal Cortex Extract (Upjohn)

Sterile solution in 10 cc. rubber-capped vials for subcutaneous, intramuscular and intravenous therapy

Upjohn
KALAMAZOO, MICHIGAN

ANOTHER WAY TO SAVE LIVES . . . BUY WAR BONDS FOR VICTORY

COOK COUNTY
Graduate School of Medicine
(In affiliation with COOK COUNTY HOSPITAL)
Incorporated not for profit

Announces Continuous Courses

SURGERY—Two Weeks Intensive Course in Surgical Technique starting November 1, 15, and 29, and every two weeks throughout the year.
MEDICINE—Courses to be announced in January.
FRACTURES AND TRAUMATIC SURGERY—Courses to be announced in January.
GYNECOLOGY—Two Weeks Intensive Course starting February 7. One Week Personal Course in Vaginal Approach to Pelvic Surgery starting November 1. Clinical and Diagnostic Courses.
OBSTETRICS—Two Weeks Intensive Course starting February 21.
ANESTHESIA—One Week Course in Continuous Caudal Anesthesia for Obstetrics.
OPHTHALMOLOGY—Clinical Course.
OTOLARYNGOLOGY—Special and Clinical Courses.
ROENTGENOLOGY—Courses in X-Ray Interpretation, Fluoroscopy, Deep X-Ray Therapy every week.
UROLOGY—Two Weeks Course and One Month Course available every two weeks.
CYSTOSCOPY—Ten Day Practical Course every two weeks.

GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES.

TEACHING FACULTY:
ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address: Registrar, 427 South Honore Street, Chicago, Illinois

St. Luke's Hospital
SAN FRANCISCO

A Limited General Hospital of 200 Beds

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Harold P. Hill, M.D.
William G. Moore, M.D.

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Fully approved by the American College of Surgeons and the American Medical Association for Resident and Intern Training.

Limited Facilities for Part-Pay Treatment

Las Encinas Sanitarium . . . . Pasadena, California
INTERNAL MEDICINE INCLUDING FUNCTIONAL AND ORGANIC NERVOUS SYSTEM DISEASES
Board of Directors: George Dock, M.D., *President;* J. Robert Sanford, M.D., *Vice-President*
Address: STEPHEN SMITH, M.D., F.A.C.P.; CHARLES W. THOMPSON, M.D., F.A.C.P.
MEDICAL DIRECTORS, PASADENA, CALIFORNIA

TWENTY-FIVE YEARS AGO

(Continued from Page 28)

Public Health, September 7, 1918, at 8 p. m., in Hamburger's Cafe.

Dr. Fitch C. E. Mattison presided. Dr. Harry Voorhees acted as secretary. The object of the meeting was to discuss "Social Health Insurance," which will probably practically emasculate the medical, dental and pharmaceutical professions, and pauperize or bankrupt the members if adopted.

Speakers were; Dr. H. A. L. Ryfkogel, San Francisco; Dr. Dudley Smith, Oakland; Dr. James Franklin Smith, San Francisco; and others.

Excerpts from Military News: Volunteer Medical Service Corps of the United States. Authorized by the Council of National Defense; Approved by the President of the United States.—What Is the Volunteer Medical Service Corps?:

The Volunteer Medical Service Corps is an organization which provides means for obtaining quickly men and women for any military or civil medical service required in the war emergency. It furnishes recommendations and necessary credentials to assure the best medical service, both military and civil.

How should application for membership be made?

Upon request to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C., application blanks and circulars of information will be sent. When received, the application form should be filled out completely, in accordance with instructions contained in the

(Continued on Page 32)

Cheplin's
Cheplin's
CC. SIZE BOTTLE
No. 262A
BISMUTH SUBSALICYLATE
2 Grains (0.13 Gm.) in each CC.
Suspended in Oil
For Intramuscular Use
SHAKE WELL
Caution: For Physicians' Use Only
CHEPLIN BIOLOGICAL LABS, Inc.
SYRACUSE, N. Y.
10
20
30 M

Bismuth Subsalicylate N. N. R.

(IN OIL WITH CHLOROBUTANOL 3%)

Intramuscular Bismuth therapy is usually well tolerated by patients who react unfavorably or are resistant to arsenicals. It has been found effective in many other cases, when alternated with arsphenamine or as a substitute for mercury compounds. Average dose: One cc. weekly.

Bismuth Subsalicylate in Oil with Chlorobutanol 3% is supplied:

Special wide mouth ampule, 1 cc.;
2 gr. (0.13 gm.) in oil.
In boxes of 12, 25 and 100.
Wide mouth bottles, 60 cc.; 100 cc.; 480 cc.
Catalogue and Prices on Request

"ACCEPTED STANDARDS AT AN ACCEPTABLE COST"

CHEPLIN BIOLOGICAL LABORATORIES, INC.
(Division of Bristol-Myers)
Syracuse, New York

Does beer drinking contribute to longevity?

For interesting comment on this subject, we refer you to an article "At what age should the lamp go out?" by Anthony Bassler, in the July, 1943 issue of Medical Record.

Acme, biggest seller in the West, is the *original* light, dry beer. It is lower in caloric content than many so-called "diet" foods. To give a specific example: an 11-ounce bottle of Acme Beer contains 154.13 calories . . . the equivalent in soda crackers, 1,464.84 calories.

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Beer
Acme Breweries

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SAN FRANCISCO LOS ANGELES

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(Continued from Page 30)

circular of information. The application should then be mailed to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C.

EXCERPTS FROM CORRESPONDENCE: LICENSE EXAMINATIONS IN FOREIGN LANGUAGE

To the Editor:—Can a California physician [November, 1918] be examined in English in Latin-America, in France or in Japan? If a certificate should be granted to a foreigner is there any legal provision whereby his practice could be restricted to his own nationality? Has the war already created such a deficit in professional men that we are obliged to remove all professional restrictions from those who cannot speak our language? Is it true that our country needs a larger element of those who cannot read or write our language and who, therefore, cannot absorb the "spirit" of America? Personally, I would answer all these questions in the negative. This country is already reaping the disadvantages of its concessions to foreign languages. The parochial schools in German, Spanish and other tongues have fostered an un-American spirit among thousands of our so-called citizens. Transitory visitors to our land should be treated with all possible courtesy, but permanent residents among us should be required to adopt our language. Unification of language is one of the most important bulwarks of a "National Spirit."

Sincerely yours,
(Signed) JOHN C. KING.

Editor's Note.—John C. King, M.D., was president of the California Medical Association in the year 1910. He celebrated his ninetieth birthday in February, 1943. See CALIFORNIA AND WESTERN MEDICINE, January, 1943, page 48.

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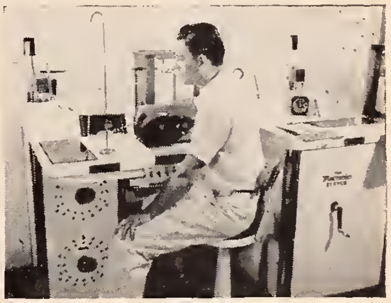

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(Continued from Text Page 300)

be made at Goa, Portuguese India. (The *Gripsholm* sailed from New York on the exchange trip September 2." (Anaheim *Bulletin*, September 22, 1943.)

"Specialists in health and medical care—particularly those trained in bacteriology, biochemistry, physiology and malaria control, dietetics, physical therapy (including aides), and nursing—are needed urgently by the War Department, it was announced today at the headquarters of Major General Kenyon A. Joyce, commanding general of the Ninth Service Command at Fort Douglas, Utah." (Fullerton *News-Tribune*, September 25, 1943.)

"The University of California Medical School announced yesterday the appointment of Dr. Alexander Simon to the position of assistant medical director of the Langley Porter Clinic for mental diseases." (San Francisco *Chronicle*, September 24, 1943.)

"A characteristic of the jungle fighting in the Southwest Pacific is the high proportion of nonfatal wounds. Japanese snipers fortunately are poor shots. Equally fortunately for our men in that area, there are plenty of highly trained medical men to care for wounds immediately. If it were not for this on-the-spot medical service, the horror of infection and death would become almost unbearable. Reporting on the heroism of the Army doctors, a news dispatch from Munda states: 'It is a heart-warming experience to watch the young surgeons working night and day, ministering to the wounded Americans in the gloomy depths of the New Georgia jungle. The main responsibility for saving lives

(Continued on Page 36)

"Till He Comes Marching Home"

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BOARD OF MEDICAL EXAMINERS

(Continued on Page 34)

rests with them. . . . It has been the aim of the medical corps in this campaign to give every wounded man preliminary treatment within a few minutes after he has been hit. . . . The Corps does its job with the bullets and shrapnel still flying.' These are the same doctors that a year ago were striving to build careers for themselves at home. Most of them have families, and all of them spent long years of study and privation preparing to practice medicine. They carry with them into battle a wealth of knowledge and the best traditions of the American medical profession. . . ." (San Carlos *Enquirer*, September 17, 1943.)

Recently Licensed Doctors of Medicine

Frederick N. Scatena, M. D., Secretary-Treasurer of the Board of Medical Examiners of the State of California, reports the results of the written examination held in Los Angeles, August 10, 11 and 12, 1943. The examination for physicians and surgeons covered nine subjects and included ninety questions. An average of 75 per cent is required to pass. Eighty-one applicants wrote the examination.

The highest mark for physicians and surgeons (91-4/9 per cent) was made by Isaac Murphy Berry, Los Angeles, California, a graduate of the College of Medical Evangelists.

The following is a list of successful applicants:

NAME	SCHOOL
Abbott, Arnold Wilson *Los Angeles*	U. of So. Calif. Sch. of Med., '43
Balline, Rose Lee *Los Angeles*	U. of Illinois Coll. of Med., '43
Becker, Robert Mettler *Los Angeles*	U. of Chicago Sch. of Med., '43

(Continued on Page 40)

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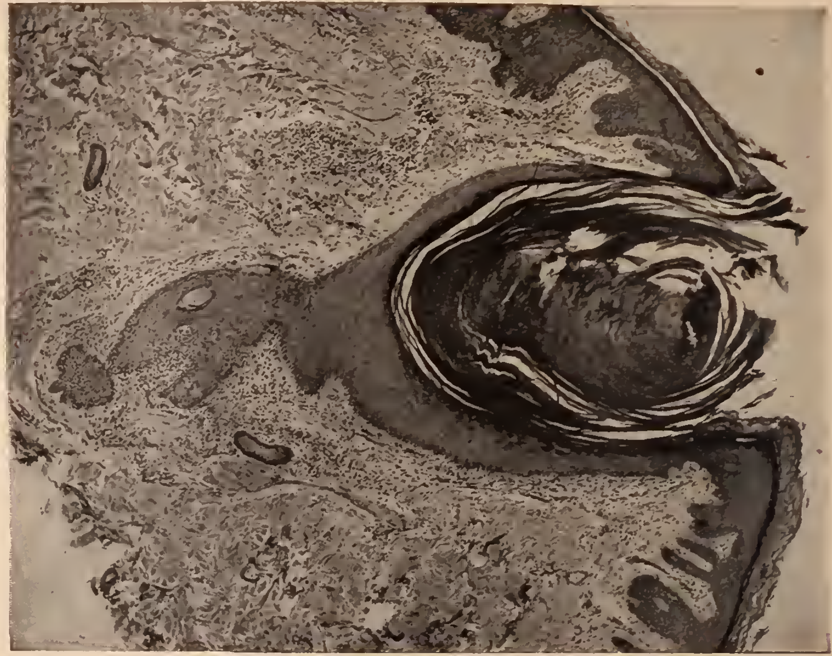

★Photographs from "The AVITAMINOSES" 1941 . . . courtesy, The Williams & Wilkins Co., Baltimore, Maryland.

THE MANIFESTATIONS OF VITAMIN A DEFICIENCIES

The gross papular eruption of the skin is due to hyperkeratosis of the hair follicle. The accompanying photographs show advanced stages of vitamin A deficiency. Other evidences of this deficiency include nutritional night blindness, xerophthalmia, keratomalacia, and possibly decreased resistance of the body to infection. Other evidences of vitamin A deficiency have been proposed but are not yet definitely established. The early signs of vitamin A deficiency are not readily determined. Two tests are available for this detection. They include tests for loss of adaption to dim light and more recently, determination of vitamin A in the blood.

Vitamin A deficiency may be anticipated when patients are on limited or reducing diets, among faddists, cases of hyperthyroidism (thyroxine is supposedly antagonistic to vitamin A), in severe infections, chronic diarrhea, biliary duct obstruction, and celiac disease. The importance of normal fat metabolism for absorption of carotene (precursor of vitamin A), is well recognized. Therefore persons on low fat diets or whose gall bladder has been removed are especially likely to develop a deficiency. Mineral oil *inhibits absorption of carotene.*

Although justification does not exist for calling vitamin A the "anti-infective vitamin," the administration of vitamin A helps establish resistance of the body to infections in general when there has been an exhaustion of body reserves of the vitamin, and the ingestion of vitamin A is inadequate.

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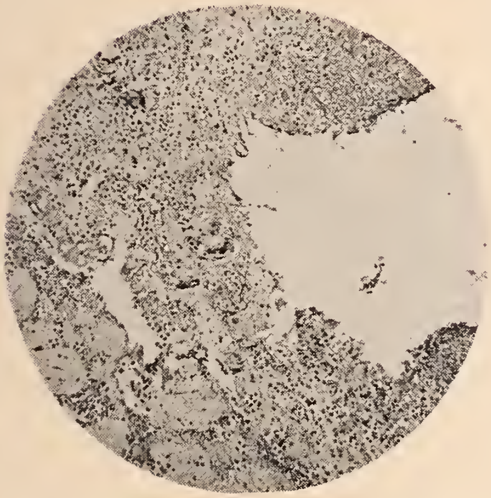
The use of sulfaguanidine for the treatment of dysentery carriers has been suggested.



Photomicrograph showing cytological detail in acute lesion of mucosa of colon. Magnification x 650.

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FAIRLY, N. H., and BOYD, J. S. K.: Brit. M. J. 2:673 (Dec. 5) 1942. (Proc., Royal Society of Tropical Medicine and Hygiene, Nov. 4, 1942).

BULMER, E., and PRIEST, W. M.: J. Roy. Army M. Corps 79:277 (Dec.) 1942.

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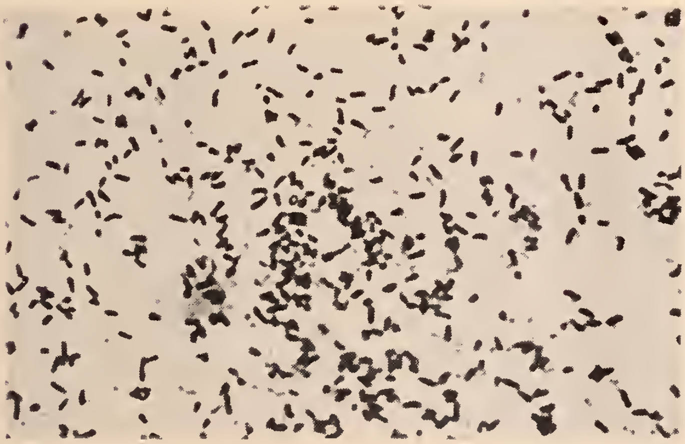
OPPER, L., and HALE, V.: J. A. M. A. 119:1489 (August 29) 1942.

KUHNS, D. M.: South. M. J. 36:393 (June) 1943.



Photomicrograph of Dysentery Bacillus—Flexner—(*Shigella paradysenteriae*). Initial magnification x 1300.

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Wilkinson, Jack Elwyn *Fresno*	Coll. of Med. Evang., '44
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Penicillin Production.—A streamlined process of Penicillin production, resulting from two years' research in the Parke-Davis Laboratories, promises to substantially cut down the production time required, according to Homer C. Fritsch, General Manager of the Company.

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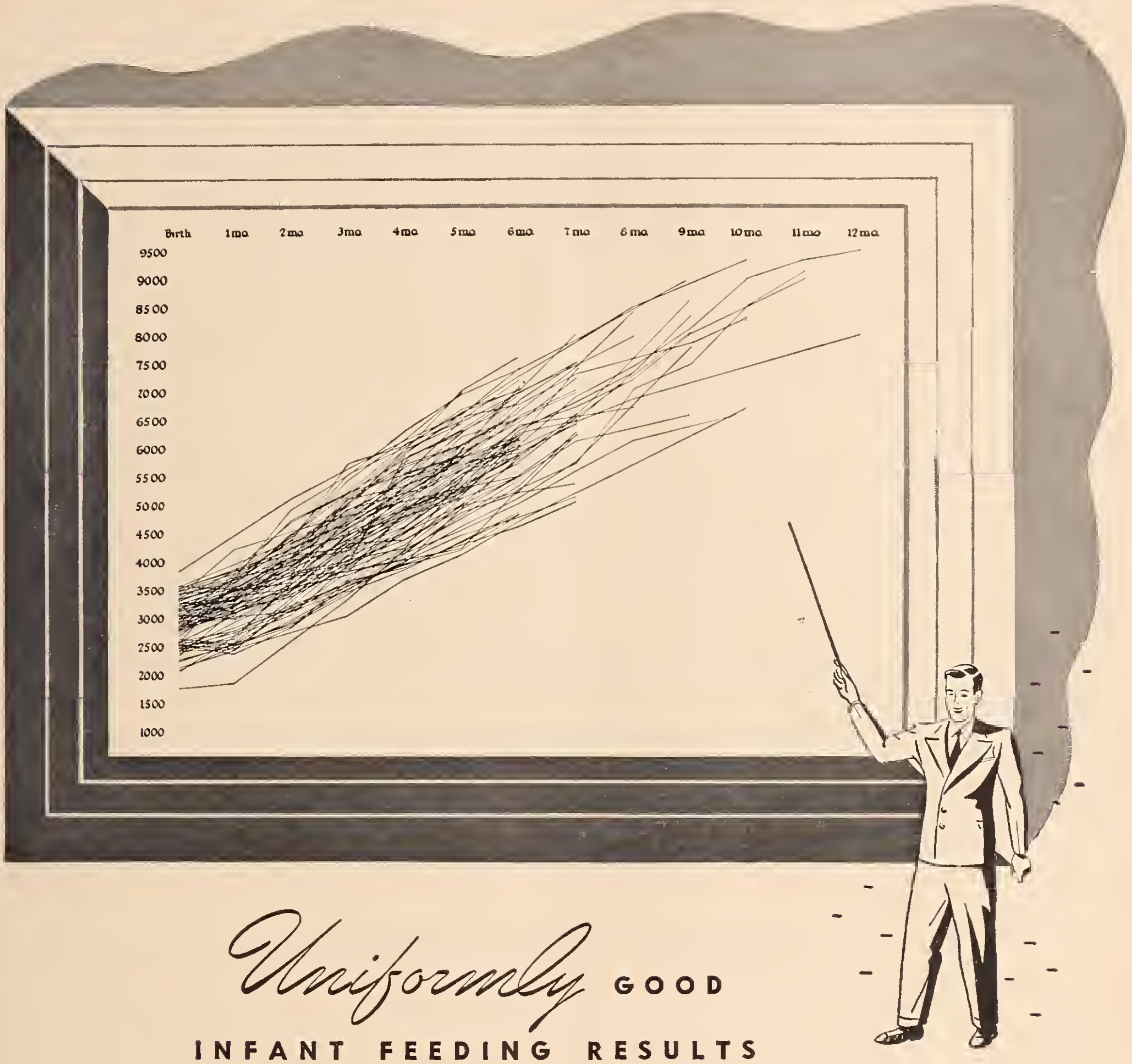

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California Tuberculosis Association: Christmas Seals. With the mail delivery of November 22, tuberculosis associations throughout the United States will inaugurate the thirty-seventh annual Christmas Seal sale.

The design, showing a child watching Santa Claus, is a cheerful reminder that Christmas will soon arrive. The double-barred cross, appearing in the lower left-hand corner, is also a reminder—that tuberculosis is still a dangerous enemy which must be brought under control.

When the Christmas Seal was introduced to the nation in 1907, tuberculosis was the "captain of the men of death" and was taking a life every three and one-half minutes. Since then it has been hammered down to seventh place among the causes of death, and the mortality rate from the disease has been reduced 75 per cent.

Control, however, is still a hope rather than a fact. Nearly 60,000 persons died of the disease last year—one every nine minutes—and only through unusual effort can an increase be avoided.

The history of past wars is a history of tuberculosis on the rise. During the present struggle all the elements that pave the way for tuberculosis breakdowns—crowded living conditions, increased physical and mental strain, migrations of workers, and inadequate nutrition—are present in greater number than ever before. In the United States, tuberculosis deaths for the country as a whole still show a drop, but in certain areas there have been increases. Authorities agree that only through the widest application of preventive measures and education can the disease be held to its present level.

Tuberculosis associations, as in years past, are leaders in the fight against the disease. The size and extent of their programs for 1944 are dependent on funds obtained through the sale of Christmas Seals.

New Aluminum Hydroxide Gel Preparation.—The value of orally administered aluminum hydroxide gel in promoting healing, relieving pain and controlling pain of gastric and duodenal ulcer, and in controlling gastric hyperacidity, is now well recognized. Various preparations have been available.

As offered by E. R. Squibb & Sons, Aluminum Hydroxide Gel is pharmaceutically an elegant preparation of a fluid consistency. The suspension is practically snow-white, pleasant to take, lacking any suggestion of astringent taste. Diluted with two or three parts of water, the Gel may be administered by gastric drip, or taken in one or two teaspoonful doses in water or milk. Aluminum Hydroxide Gel, Squibb, is available in 12-ounce bottles.

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*Himes, *Medical History of Contraception*

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Doctor! Will you give *my* daddy a message?

DADDY doesn't know me very well, on account of he's overseas and he hasn't seen me yet. But he worries about me something awful.

Why, just the other day I heard Mama say that he's all upset because our fats are rationed, and tin for canning is so scarce. He's afraid Mama may not be able to keep me on the food my doctor prescribed when he found she couldn't nurse me.

Tell Daddy not to worry, Doctor. The men in Washington are doing everything in their power to provide the folks who make S-M-A (that's my brand) and all the other manufacturers of scientific infant formulas with enough cans, enough special fats, and enough other ingredients to give us babies our full quota of nutrition.

See, Doctor? Daddy needn't worry for a single minute! Our government isn't going to let its babies go without foods they need so they can grow up to be strong and healthy. Just remind him, Doctor—that this is America!

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HOW CAN A DOCTOR HAVE A MERRY Christmas?

You are a healer, a saver of life . . .

Yet, this Christmas you see a world intent on maiming, on killing.

You wish you were out where the wounded and dying are, doing everything in your power for them . . .

But, circumstance holds you and commands, "Stay, do your work here—where the need for it is greater than ever before!"

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So, to wish you a *merry* Christmas at this time would be to wish you the impossible.

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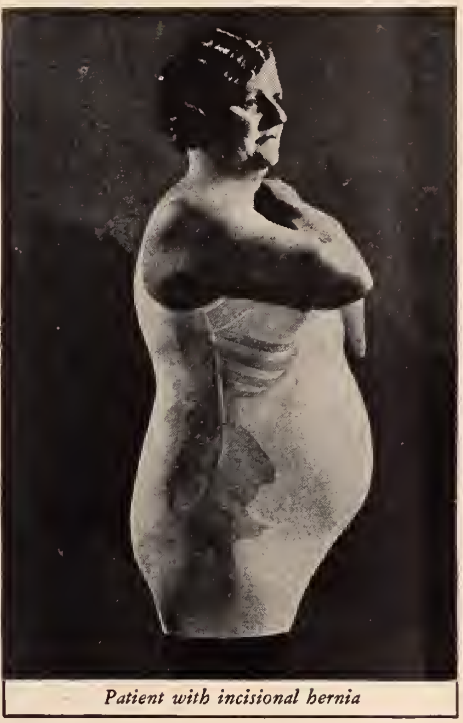
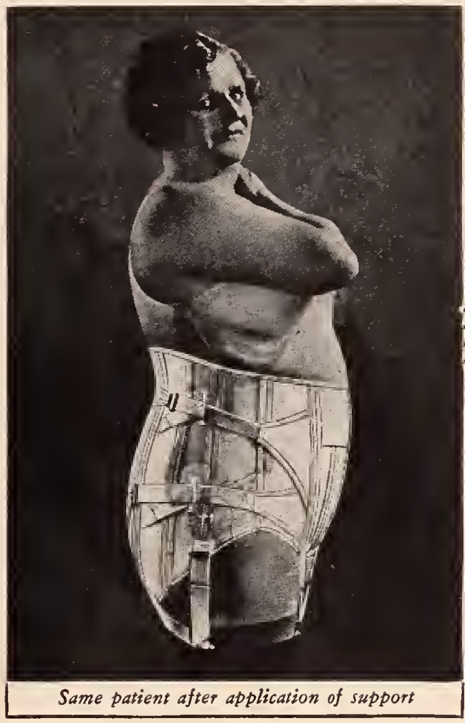


Patient with incisional hernia



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Secretary, J. M. Boomer, American Trust Building, Richmond.
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Secretary, Jerome A. Thormann, 2607 Fresno Street, Fresno.
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Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society

President, T. E. Bartholomew, 319 Third Street, Calexico.
Secretary, Henry Forcher, 319 Third Street, Calexico.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

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Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

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President, John H. Lloyd, Fort Bragg.
Secretary, Louise E. Petty, Talmage.
Meeting, *On Call.*

Merced County Medical Society

President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society

President, Rollin Reeves, 32 E. San Luis Street, Salinas.
Secretary, S. Condit Glasgow, 8 E. Alisal Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society

President, I. E. Charlesworth,* Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association

President, D. A. Harwood,* 2145 Walnut, Santa Ana.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society

President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society

President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement

President, Edward S. Babcock, 1127 Eleventh Street, Sacramento.
Secretary, Carl E. Burkland, 510 Medico-Dental Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society

President, J. M. O'Donnell, Hollister.
Secretary, J. J. Haruff, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society

President, Kenneth L. Dole, Medical Arts Building, Redlands.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society

President, W. Don Rolph, 640 National Avenue, National City.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

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President, Sidney J. Shipman, 490 Post Street, San Francisco.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco.
Meeting, *Second Tuesday, 8:15 p.m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, Curtis M. Galt, 134 N. Lincoln Avenue, Manteca.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society

President, F. F. Ragsdale, 717 Twelfth Street, Paso Robles.
Secretary, Harrison Eilers, Box 360, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

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President, William A. Key, 23 Second Avenue, San Mateo.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society

President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association

President, J. Irving Beattie,* 652 E. Santa Clara Street, San Jose.
Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society

President, F. P. Shenk, Medico-Dental Building, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
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President, Oscar Jess Hansen, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society

President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society

President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society

President, Clifford M. Carlson, 576 B Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society

President, Terry T. Laird, 107 Crescent Road, San Anselmo.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society

President, Frank L. Doane, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society

President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society

President, G. C. Coffey, Bank of America Building, Ventura.
Secretary, M. M. Raines, 34 North Ash Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society

President, Ray E. Nichols, Woodland.
Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

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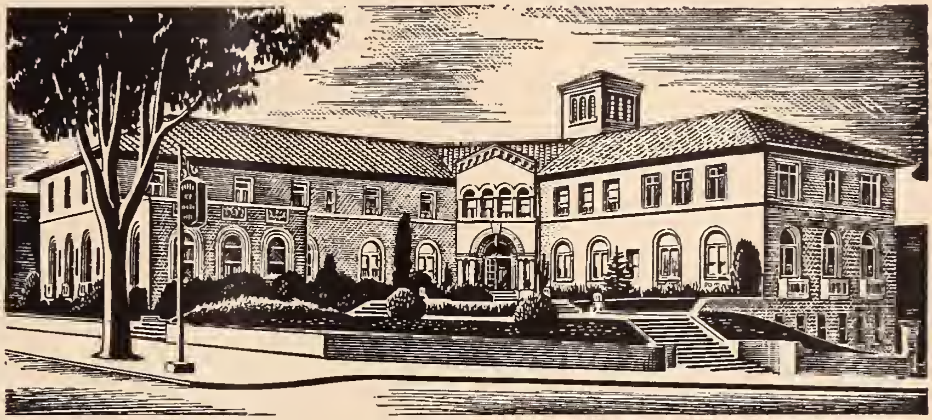

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BOOKS RECEIVED

Annual Report of the Board of Regents of the Smithsonian Institution. Showing the Operations, Expenditures, and Condition of the Institution for the Year Ended June 30, 1942. Cloth. Price, $1.50. Pp. 421. Washington: United States Government Printing Office, 1943.

International Health Division Annual Report, 1942. Paper. Pp. 194. 49 West Forty-ninth Street, New York: The Rockefeller Foundation, 1943.

The Medical Clinics of North America. Boston Number. Cloth. Pp. 1446. Philadelphia and London: W. B. Saunders Company, 1943.

Clinical Audiometry. By C. C. Bunch, M. A., Ph.D., Formerly Associate Professor of Otology, Medical School, University of Iowa; Associate in Research Otology, Johns Hopkins University; Professor of Applied Physics of Otology, School of Medicine, Washington University; Associate Director of Central Institute for the Deaf, St. Louis; Research Professor in Education of the Deaf, School of Speech, Northwestern University. Cloth. Price, $4. Pp. 186, with seventy-four text illustrations. St. Louis: The C. V. Mosby Company, 1943.

BOOK REVIEWS

Pain. By Thomas Lewis, M. D., F. R. S., Physician in Charge of Department of Clinical Research, University College Hospital, London; Fellow of University College, London. Cloth. Pp. 192, with 26 illustrations and frontispiece. New York: The Macmillan Company, 1942.

As stated in the preface: "The chief purpose of this

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BOOK REVIEWS

(Continued from Page 7)

book is to review modern ideas of the mechanism of pain and to bring into perspective with other observations the work of my own laboratory during the last ten years." Although Sir Thomas' time and attention the past decade have been chiefly occupied with investigations upon the nature of pain, he feels that the present work is far from complete; but, because the war has postponed further studies, he has decided to summarize the "tentative views" arrived at to date.

This monograph on pain is written in the usual clear manner in which Sir Thomas writes. Its organization is logical, and from the reader's point of view, practical in that it proceeds gradually from the well-known facts about pain into the less known and more recent discoveries. It contains much factual data gathered from work upon the human being, since pain, *per se,* is subjective, and deductions based upon animal experimentation are open to question.

The subject is developed from the known pain produced by injuries to the skin, through the muscle pain of ischemia, referred pain, and concludes with three chapters upon visceral pain and a final chapter entitled, "Principles in the Clinical Use of Pain."

A bibliography of 253 references and a good index complete the volume, which is highly recommended to neurologists and internists. It could well be prescribed reading for medical students in their clinical years, since pain, in its largest sense, is the most frequent complaint which causes patients to consult a physician.

J. Marion Read.

(Continued on Page 14)

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WANTED—Association with group, partnership, industrial surgery, by surgeon. F. A. C. S., gentile; many years surgical experience on metropolitan hospital staffs; prefer California or Washington. Address: Box 9070, California and Western Medicine.

More Help for Milk-Allergic Patients.—Appetizing and nutritious recipes for using Mull-Soy in milk-free diets are now available in a new publication of Borden's Prescription Products Division. Already widely prescribed as a hypoallergenic substitute for milk in infant formulas, Mull-Soy is now proving equally useful in diets of older infants, children, and adults who are allergic to milk.

Mull-Soy is an ethically marketed soybean food in liquid emulsified form. It is palatable, readily digestible, well-tolerated, and easy to use. Although hypoallergenic in most cases of milk allergy, it nevertheless closely resembles milk in nutritional values of protein, fat, carbohydrate, and minerals.

Included in the new Mull-Soy recipe folder are numerous beverages, soups, and desserts, as well as directions for using Mull-Soy in place of milk or cream for cereals, coffee, mashed potatoes, etc.

These Mull-Soy recipe folders are designed for distribution by physicians to their patients. Any desired number of copies may be obtained by writing to Borden's Prescription Products Division, Department CB, 350 Madison Avenue, New York, 17, N. Y.

New Research Assistant.—Dr. Charles F. McKhann, who has for several years been on the faculty of the University of Michigan, has resigned from that institution to accept a position as assistant to the president of Parke, Davis & Company. Doctor McKhann will devote his time entirely to the scientific activities of the Company. He assumed his new duties on October 15.

At the University, Doctor McKhann has held the positions of professor of pediatrics and communicable diseases in the Medical School, and professor of maternal and child health in the School of Public Health. He has also acted as consultant to the Secretary of War in the control of epidemic diseases.

Doctor McKhann has had an interesting and exceptional background of experience. The summer of 1941, previous to coming to the University of Michigan, he acted as consultant to the Board of Health, Territory of Hawaii. From 1936 to 1940 he held the position of associate professor of pediatrics and communicable diseases at Harvard Medical School and Harvard School of Public Health. Before that he spent a year as visiting professor of pediatrics and communicable diseases at Peiping Union Medical College, Peiping, China.

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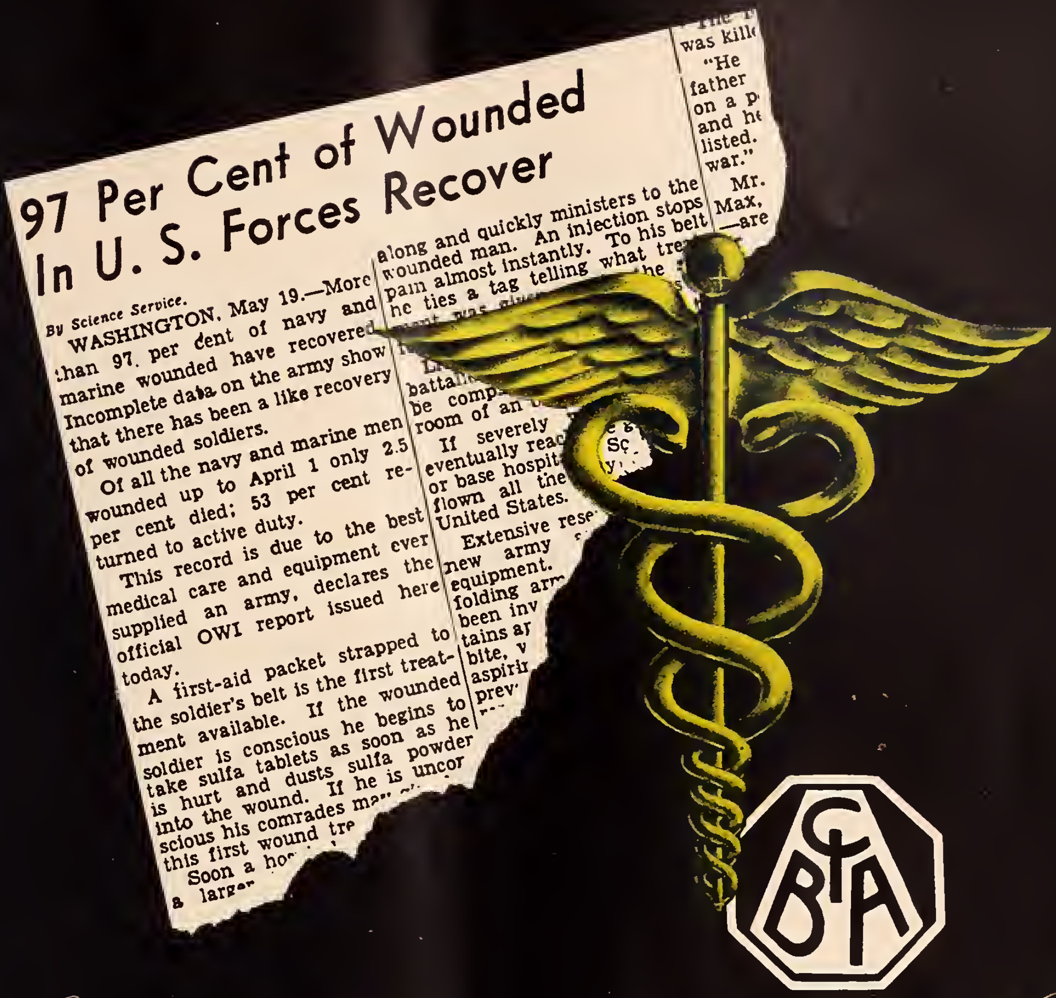

97 Per Cent of Wounded In U. S. Forces Recover

By Science Service.

WASHINGTON, May 19.—More than 97 per cent of navy and marine wounded have recovered. Incomplete data on the army show that there has been a like recovery of wounded soldiers.

Of all the navy and marine men wounded up to April 1 only 2.5 per cent died; 53 per cent returned to active duty.

This record is due to the best medical care and equipment ever supplied an army, declares the official OWI report issued here today.

A first-aid packet strapped to the soldier's belt is the first treatment available. If the wounded soldier is conscious he begins to take sulfa tablets as soon as he is hurt and dusts sulfa powder into the wound. If he is uncor
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along and quickly ministers to the wounded man. An injection stops pain almost instantly. To his belt he ties a tag telling what tre

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Mr.
Max,
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Salute to Distinguished Service

● It is a tribute to the Medical Corps of the fighting forces and to American research that *more than 97 per cent of Navy and Marine wounded recover,* and that 53 per cent return to active duty. Present Army records show like recovery of wounded soldiers.

Such a record could not have been established without skilled medical care in the field—and without products of American pharmaceutical manufacturing laboratories . . . always searching for improvements in existing preparations, always seeking new and more effective medicaments.

As one of these manufacturing laboratories, Ciba salutes the Medical Corps of the American Armed Forces for brilliant use of vital therapeutic aids.

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Does beer drinking contribute to longevity?

For interesting comment on this subject, we refer you to an article "At what age should the lamp go out?" by Anthony Bassler, in the July, 1943 issue of Medical Record.

Acme, biggest seller in the West, is the *original* light, dry beer. It is lower in caloric content than many so-called "diet" foods. To give a specific example: an 11-ounce bottle of Acme Beer contains 154.13 calories . . . the equivalent in soda crackers, 1,464.84 calories.

ACME BREWERIES
SAN FRANCISCO LOS ANGELES

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Beer
Acme Breweries

BOOK REVIEWS

(Continued from Page 10)

Gynecology and Female Endocrinology. By Emil Novak, A.B., M.D., D.Sc. (Hon. Dublin), F.A.C.S., Associate in Gynecology, The Johns Hopkins Medical School; Gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore; Fellow, American Gynecological Society, American Association of Obstetricians, Gynecologists and Abdominal Surgeons and Southern Surgical Association; Honorary Fellow, Royal Institute of Medicine, Budapest; Sociedad d'Obstetricia et Ginecologia de Buenos Aires; Central Association of Obstetricians and Gynecologists; Texas State Association of Obstetricians and Gynecologists; Past Chairman, Section on Gynecology and Obstetrics, American Medical Association. Cloth. Price, $10. Pp. 605, with 574 illustrations. Boston: Little, Brown & Company, 1941.

As the author states in the preface, this book is a new departure in gynecological textbooks in the emphasis given endocrinology and the omission of detailed surgical techniques.

The first eight chapters cover the anatomy of the reproductive organs, and the physiology, endocrinology and histology of menstruation. There is an excellent chapter on the anovulatory cycle in women. The not infrequent occurrence of this phenomenon in adolescence and those approaching the menopause, as well as its sporadic occurrence through the menstrual life of normal women, has been demonstrated by endometrial biopsy. The inadequacy of any commercial hormone preparation to bring about ovulation is discussed.

Chapters nine to thirty-four cover diseases of the genital organs, fistulas and relaxations, benign and malignant tumors. The three chapters on ovarian tumors, benign, malignant and functioning, are very clearly written and well illustrated. There is a good chapter on backache in women.

Chapters thirty-four through forty are devoted to gynecological organotherapy. No attempt is made to list the commercial products by trade names, but chapter thirty-four gives an excellent summary of available commercial preparations in each hormone group and indications for use. The list includes estrogens, progesterone, chorionic hormone, androgen, thyroid, and notes briefly the disappointing results in the use of pituitary sex hormones now available and of equine gonadotropic hormone in precipitating ovulation.

The subsequent chapters discuss menstrual abnormalities, menopause, sterility, and the management and endocrine therapy for each condition. The author gives detailed instructions as to preparation, dosage and time (in cycle) of administration.

The last two chapters are on related endocrinopathies and pregnancy in gynecological practice.

The unique value of the book lies in its defining the scope and limitations of our newer knowledge of endocrine therapy in gynecology. The limitations are still great.

The book is simply, concisely and well written by an authority in gynecological pathology and endocrinology. It fulfills the author's expressed purpose in writing a textbook for medical students and general practitioners most excellently. GERTRUDE FLINT JONES.

The Effect of Aspirin on the Gastric Mucosa.—Acetylsalicylic acid does not produce hyperemia or cause hemorrhages in the gastric mucosa. In doses as high as 80 grains per day it does not cause any gastroscopically demonstrable changes in the stomach. Its ingestion over long periods of time does not produce chronic gastritis.

The epigastric distress which sometimes occurs after the ingestion of acetylsalicylic acid might be the result of increased acid production and pylorospasm.—W. D. Paul, Des Moines, in *Journal of Iowa State Medical Society*, 33, 155, 1943.

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  1, 2, 3, 4, 5, 6.
- Macrocytic anemias of pregnancy
  7, 8, 9
- Sprue
  10, 11, 12, 13, 14, 15.
- Anemia associated with Hepatic insufficiency
  16, 17, 18, 19, 20.

It is believed that further trial of parenteral liver extracts in these conditions, in addition to all the other measures indicated, will prove a valuable addition to therapy.

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Literature on request.

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 352)

have their origin in diseases of the nose and naso-pharynx are, in the majority of cases, due either to suppuration of the nasal accessory sinuses or to malignant growths of the naso-pharynx that spread into the cranial cavity with necrosis and suppuration as secondary results. . . .

From an Article on "Dispensary Treatment of Diabetics," by Arthur Stanley Granger, M.D., Los Angeles.—The problem of the treatment of ambulatory diabetics, particularly among the uneducated class, has always been a serious one. The educated individual can more often be made to realize the value of keeping within his or her sugar tolerance, while it is hard to impress upon the dispensary class the necessity of strict care in the diet; most of them not realizing its importance, so long as they can attend to their daily duties with a minimal amount of discomfort. It is with this group of dispensary patients that we have to deal in this paper. . . .

From an Article on "Clinical Results Following Prophylactic Treatment with Silver Nitrate for Blenorrhea Neonatorum," by Alfred Baker Spalding, M.D., San Francisco.—Congenital blindness has been a plague of the ages. However, with the discovery of the gonococcus by Neisser in 1879, together with a report by him that he had found the gonococcus in seven cases of ophthalmia neonatorum, came the clinical statement in 1883, by C. F. Crede, that blindness of the newborn could be prevented by the simple expedient of instilling into each eye at birth of two drops of a 2 per cent solution of Agno$_3$. . . .

From an Article on "Acute and Subacute Unilateral Infectious Nephritis Without Pyuria from the Affected Side," by Robert V. Day, M.D., Los Angeles.—In a recent

(Continued on Page 18)

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

contribution on Renal Infections, Keyes states the following: "Pus and bacteria are never absent from the urine excreted by the infected kidney, exception made for perinephritis, and about 5 per cent of cases of focal suppurative nephritis. These are so hyperacute that they produce symptoms due to suppuration within the parenchyma without discharging any appreciable pus into the renal pelvis." I take it this may well express the observation among urologists in general. . . .

Excerpts from Correspondence.—Concerning Anesthetists: The Rockefeller Institute for Medical Research, New York. War Demonstration Hospital.

To the Editor:—A gradually increasing misconception of the Art of Anesthesia has led to a rather unique condition of affairs.

We find that nurses and other lay persons may, by the simple acquisition of a few rules, become anesthetists. Large institutions have adopted the nurse anesthetist upon grounds of economy, expediency and even sentimentality. It is argued that these workers can be employed at little expense, that the supply meets the demand and that the feminine element eliminates fear and works for smoothness during the induction of the anesthesia.

These institutions may employ lay persons to take their x-ray pictures and to make urinary, blood or sputum examinations, but does anyone dream of speaking of these workers as the hospital Roentgenologist or the attending Pathologist? They are employed as technicians. The nurse who administers an anesthetic is an anesthetic technician. . . .

Excerpts from County Societies—County Medical Meeting of November 2: At the Los Angeles City Board of Health the Los Angeles Medical Society was called to order by the president, Dr. William Duffield. Doctor Powers, chief health officer, furnished the influenza masks for the occasion. . . .

Dr. Woods Hutchinson, of Redlands, complimented the health department and advisory committee. "Six weeks ago I went to Boston, where we doctors studied the disease and made a report to the Medical Reserve Corps.

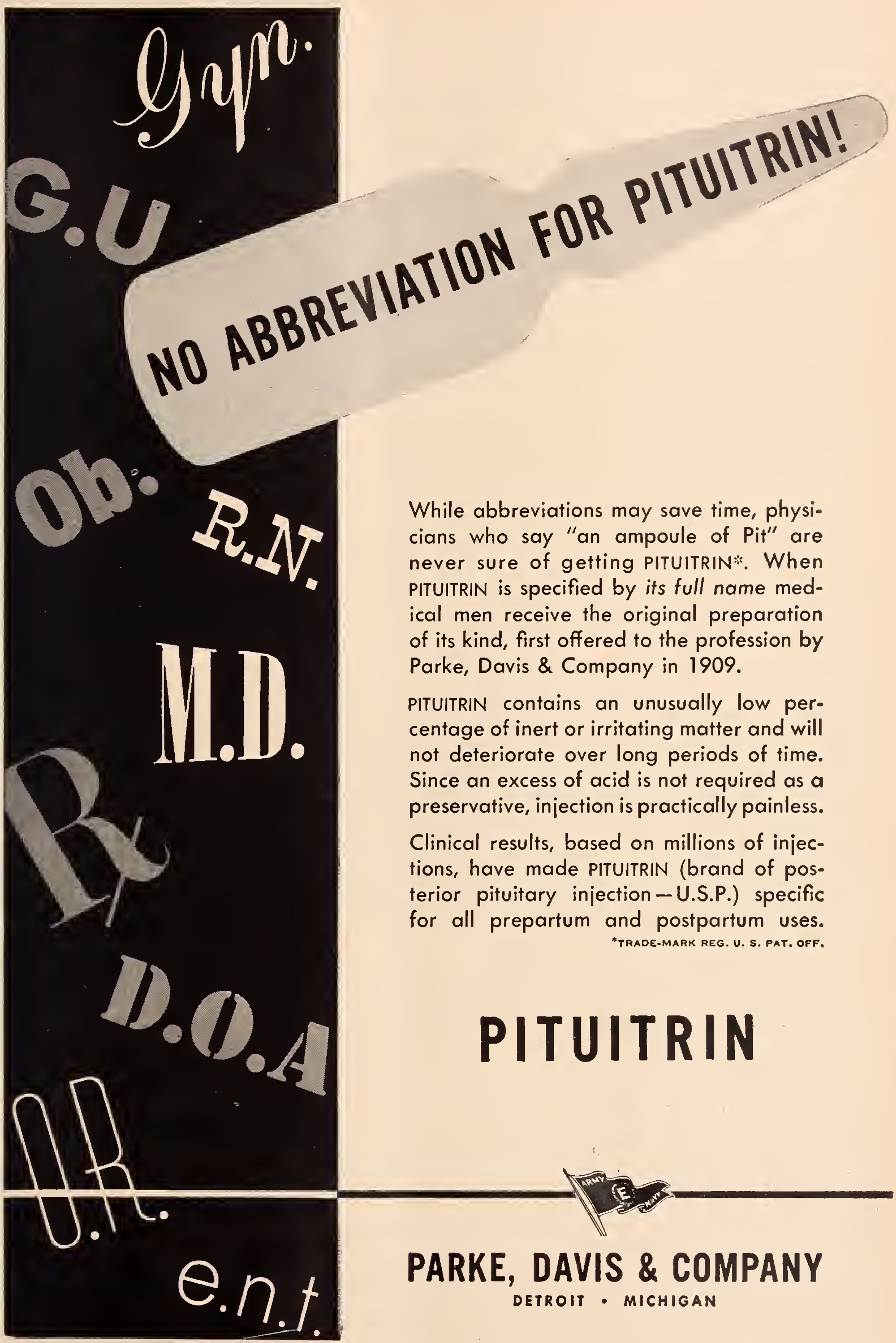
"In Boston the epidemic is terrific. I stopped in big cities to study the disease. Experts on the 'flu' declare it is the same old Pfeiffer Bacillus. There have been five epidemics: one during the Napoleonic war, others started in Asia in 1830, '60, '99 and again sixty years later, usually every thirty years. Most of us have acquired immunity.

"The present epidemic is called the Spanish Influenza. Belligerent censors denied its presence, whereas neutral Spain had nothing to hide. There were 200,000 cases in the German army, which accounted for three months of inactivity after the Russian collapse.

"In mild cases the patient may not go to bed. When it was first brought to camps there were only 200 deaths out of 20,000 in three weeks. However, there were a thousand deaths out of 14,500 cases. Young men of military age and four times more men than women have it. Two-thirds of the cases are between 20 and 40 years. The same type increases in virulency. It spreads by attacking man, then child, then old women and young women.

"Eighteen thousand deaths took place in the cantonments; more than were killed in the battle-line. In Boston, influenza killed 4,000 in three weeks; 125,000 individuals were affected. Every place will have about the same death rate. . . ."

(Continued on Page 20)



While abbreviations may save time, physicians who say "an ampoule of Pit" are never sure of getting PITUITRIN*. When PITUITRIN is specified by *its full name* medical men receive the original preparation of its kind, first offered to the profession by Parke, Davis & Company in 1909.

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

Doctor Zeiler was asked by Doctor Duffield several times to give his views as an expert bacteriologist. Doctor Zeiler doubted the use of vaccines, that are not made of the specific germs involved, and offered to manufacture a big lot of Leary's Vaccine at cost to the Los Angeles Board of Health for free distribution, which offer Doctor Powers accepted.

Doctor Barrows cautioned not to expose the patients to drafts or breezes, that they should be well covered, kept warm and moist and not given cold alcoholic rubs. The patient should not be given cold water to drink lest he vomit. Aspirin and other salicylates hurt the heart. He cautioned about observing proper care in wearing masks or they might become a source of danger. . . .

Personal.—Three medical officers, including Dr. George H. Kress, seventeen nurses and twenty orderlies contracted influenza during the establishment of a hospital for the University of Southern California Students' Army Training camp of the United States Army [December, 1918]. . . .

Local Draft Boards Need Doctors.—Physicians and surgeons who can spare time to serve on the local draft boards are requested to communicate with Dr. William Duffield, 516 Auditorium Bldg., president of the Los Angeles Medical Association.

(Continued on Page 22)

28 WORDS tell the story . . .

Clinical tests* showed that when smokers changed to PHILIP MORRIS Cigarettes, every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

**Laryngoscope, Feb. 1935, Vol. XLV, No. 2—149-154.*

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* *In Military Service*

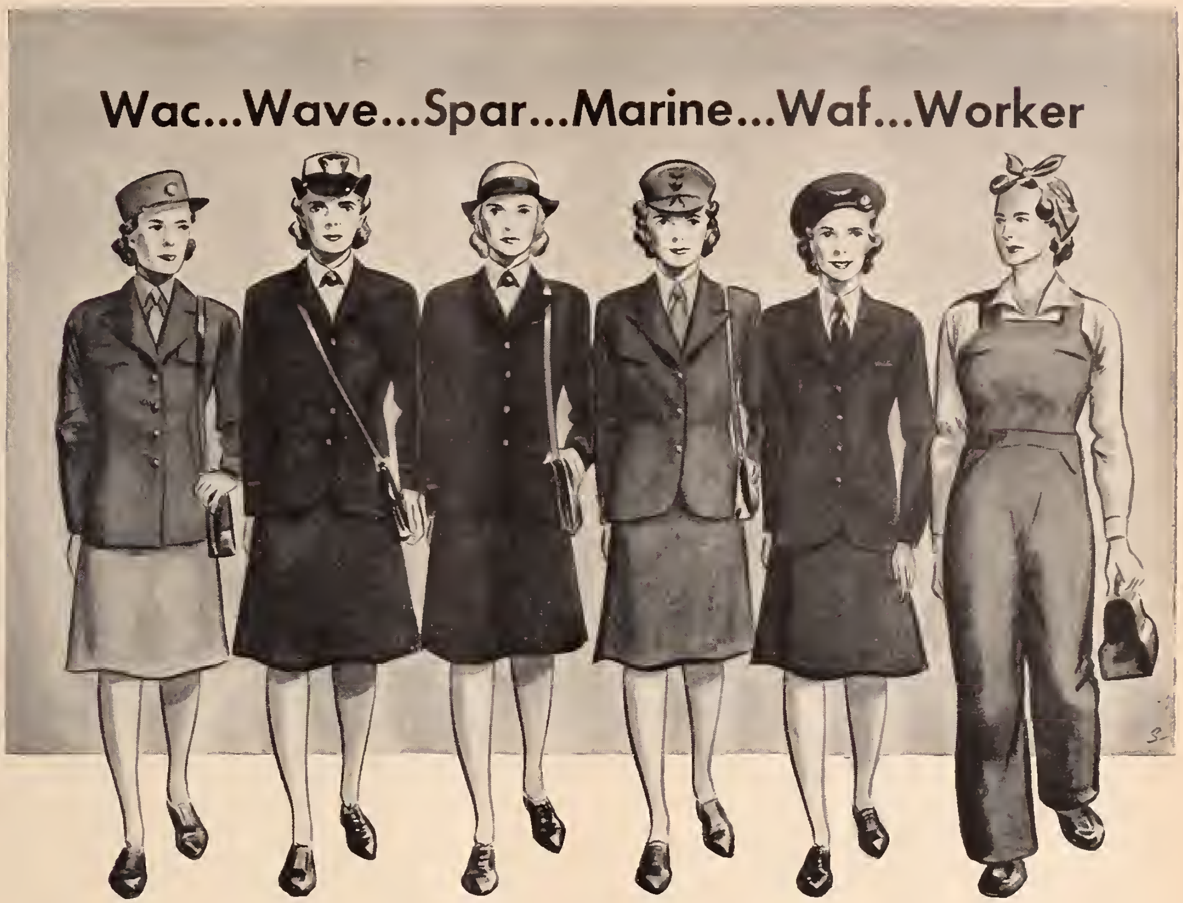
TWENTY-FIVE YEARS AGO

(Continued from Page 20)

Excerpts from State Board of Medical Examiners—Review of Activities: The annual meeting of the Board of Medical Examiners was held in the State Capitol, Sacramento, Calif., October 21 to 24, inclusive. Present, Doctors Alderson, Campbell, Molony, Phillips, Pinkham, Sisson, and Tasker. An examination of applicants for all classes of certificates was conducted. Forty-nine applications for written examination were filed and thirty-six applicants appeared, of which ten wrote the examination in the Japanese language, the questions being first translated into Japanese. As usual, the answers to the questions written in Japanese by these applicants will be translated into the English language by an interpreter unknown to the applicants. . . .

Directory.—It was determined that future editions of the Directory should be arranged alphabetically by counties to meet the popular demand for such an arrangement, thus making it possible to determine what licentiates are practicing in a specific locality. . . .

Annual Tax.—Many states are incorporating in their Medical Practice Acts a provision for the imposition of an annual tax or registration fee, as such a regulation provides a method whereby the Board is kept in closer touch with its licentiates; affords a method of discovering fraud in the impersonating of a licensed physician by one not so licensed and affords an added check on violators of the Medical Act. . . .



. . . they still are women

WHATEVER part in the war effort women elect for themselves, they still face certain physiologic upsets peculiar to their sex. Many of these gynecologic disorders are referable to ovarian or hypophyseal dysfunction.

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DECEMBER...the star of Bethlehem and the bombs of Pearl Harbor...the Prince of Peace and the god of war ☆ Christmas will have little meaning to the thousands of physicians who serve their country and perhaps to thousands more who strive to carry on at home. There is little time for exchange of pleasantries in the grim business of winning a war ☆ But the Christmas Season will come again when the forces of evil are dead—when man again will do unto others as he would have done unto him.

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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C. M. A. department, see index below.)

Committee on Publications

F. Burton Jones........Vallejo 1944
Francis E. Toomey........San Diego 1945
George W. Walker (Chairman)........Fresno 1946
Secretary-Editor........ex officio

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EDITORIALS

SEASON'S GREETINGS: TO MILITARY COLLEAGUES AND TO PHYSICIANS STILL AT HOME

A Fateful Twelve Months.—A year, fraught with major changes in the world and to our own country, is nearing its close. Within its own limited domain the medical profession itself has witnessed the transfer of more than fifty thousand of its younger members from civilian to military environments. At the same time, physicians still at home are faced not only with increased duties, but with legislative proposals which, if enacted—through proposed legal enactments threatening to make for a depreciation in the quality of medical service and its capacity to safeguard the health of the people—will radically change medical practice.

Those of us who are not eligible to join with our colleagues who are now serving in military camps on this Continent and overseas have, therefore, a double obligation, in that we must not only meet, from day to day, our former and new responsibilities, but are obliged to protect the interests of fellow physicians who are in the armed forces and no longer here in person to speak for themselves.

* * *

Roster of Military Colleagues Appears in This Issue.—Elsewhere, on page 323, in this issue appears a roster of more than two thousand members of the California Medical Association who are now serving as officers in the Medical Corps of the Army and Navy. The Editor has been able to secure these listings from the secretaries of the component county medical societies, for whose coöperation thanks are given. The roster is arranged by counties, and county secretaries should feel free to send in corrections or subsequent additions. That, indeed, would be a small "Pro Patria" gesture. Certainly, the names of colleagues who have volunteered in service to our country should be a matter of record in the OFFICIAL JOURNAL.

This enrollment score, of no less than 2,055 California Medical Association military colleagues (as of December 6, 1943) is one in which the California Medical Association may take justifiable pride.

* * *

The Season's Felicitations.—At the close of this current year, 1943, their fellow members still practicing in California salute their military colleagues, and extend to them and theirs, wherever they may be, warmest felicitations and good wishes, not only for the Christmas Season, but for the New Year and all the days ahead.

Also, to members who remain at home, sincerest greetings are extended by CALIFORNIA AND WESTERN MEDICINE.

May all of us, as the months go by, remain alert to the highest and best interests of organized and scientific medicine and the public health, wherever it shall be decreed we are called upon for service.

PUBLIC OPINION ON MEDICAL MATTERS: ITS RELATION TO LEGISLATION

Change of Public's Attitude to the Medical Profession.—During the last decade or so, it has become increasingly apparent that the medical profession has been losing influence in relation to legislation that has a direct bearing on public health activities, or on the standards and system of medical practice. Not that individual physicians are held in less regard than in days of the past, but rather, in their conjoint set-up, as represented by organized medicine—namely, national, constituent state and component county medical societies—the profession is looked upon with more or less suspicion by many members of the United States Congress and by State and local legislative bodies. And, it may be added, likewise by thousands of citizens.

* * *

Reasons for the Change.—This unfortunate state of affairs is recognized by a host of physicians, many of whom are asking themselves, What has brought about this changed reaction of national and other legislators to organized medicine?

The answer is more difficult to find since, by and large, the record of the medical profession shows that physicians have been sponsors and promoters of most of the safeguarding public health legislation placed upon the statute books of the nation, the states, and the local communities, all designed to protect the health of the people, even though to the disadvantage of the lessening incomes of physicians. To be remembered, also, is that this great service to the people has been rendered, in most cases, in quiet, unostentatious manner; and that since there is little of the spectacular in most of such endeavors, the work so performed has received a minimum of publicity, and but a modicum of thanks, in the daily press.

By contrast, every error, such as an overcharge by an individual physician, or a malpractice suit, or a difference of opinion with cultist or mercenary-commercial groups, has been so insistently portrayed in public prints, most often with bold-face captions, that there is little wonder that thousands of citizens should have gradually accepted erroneous ideas concerning the purposes of medical societies. Nor is it surprising that a large number of persons believe that a "medical trust" does exist; and that, to many, our national organization—the American Medical Association—is not visualized as dedicated to conserve the best interests of the public health and scientific medicine, but rather that it is nothing more than a sort of capitalist or labor union well deserving the term "A. M. A. Trust," so often hurled at it.

Present-Day Conditions Bring All This to the Front.—The present-day war conditions have made many physicians appreciate more clearly the significance of the above changes in public opinion, particularly when they have been confronted with difficulties in presenting legitimate criticism to some governmental procedures in which the interests of the public health and scientific medicine would be, or are, placed in jeopardy. This deplorable situation has been particularly impressed upon those officers and executives of medical organizations who, in efforts to promote legitimate public health and associated work, have often found themselves very much handicapped; in that public officials, whose aid they have sought for legitimate interests, were quietly, or openly, not only not interested, but even opposed or antagonistic.

* * *

How May Conditions Be Improved?—It is proper, therefore, to ask, What are the means that may be taken to bring about a betterment in these conditions?

* * *

Newspaper Publicity Cannot Be Altered.—It must be admitted that little can be done as regards newspaper publicity. For example, physicians, who yearly may be giving thousands of dollars' worth of gratuitous service to indigent and near-indigent citizens in public and charity hospitals, will continue to carry on their work, even though they are aware that the press will find no news value in the reports of such services. And even if the reports were printed, it is probable that the majority of readers would pass the items by, unread; for such, unfortunately, in these days of radio and headline transmittal of news, is now the mental attitude of many persons.

On the other hand, terrific pressure is needed to prevent publication of a scandalous or controversial subject related to a single physician or group, even though the basic facts are in error. And when corrections are sent in, the later presentations of such, so far as display is concerned, in only rare instances are commensurate with the erroneous first recital.

* * *

The Solution Must Be Found in New Forms of Medical Approach, Akin to Those in Vogue by Business and Allied Groups.—Since the State of California has been what might be called—and this is stated in no derogatory sense—the guinea pig for a special number of social welfare and associated ideologies and plans, and therefore has had more experience therewith than many other commonwealths, it may be in order to call to the attention of medical organizations some of the things that physicians of this State have learned through such personal knowledge.

Here in California in 1911 and before, initiative and referendum votes by the electorate had their early try-outs. For instance, reference may be made to the attempt in the election of November, 1918, to enact a compulsory health insurance law for California. One writer, in 1926, commenting thereon, stated: "The California League for the Conservation of the Public Health defeated social health insurance, despite all its propaganda, official endorsements and influential backing, by the conclusive majority of 224,466."

* * *

California's Public Health Leagues.—Those early experiences laid the foundation for the establishment, early in 1918, of the original "California League for the Conservation of the Public Health," the purposes of which appear in the footnote below.[1]

After some years of active work, under many officers who were then prominent in organization work in the California Medical Association, the original League, for reasons not necessary here to relate, gradually faded out of existence. However, the organization was instrumental in the formation of similar groups in Oregon, Washington, and other western states. Its efficient service during those early years is indicated in a tribute, given in 1926, by the well-known California publicist, Chester H. Rowell.[2] The item is of special interest here, as showing that, even at that date, public opinion was aligning itself against organized and scientific medicine.

* * *

Sound Reasons Exist for the Existence of Public Health Leagues.—The first California League was organized, in part, to permit physicians who, as citizens, were interested in the maintenance of adequate public health standards, to work through an agency in which legitimate remedial legislation might be so promoted, that a minimum of reproach would be cast upon the California Medical Association, an organization designed to be scientific in nature and function.

So sound were the basic reasons for the existence of such a separate organization—composed of physicians, dentists, pharmacists, nurses, and other citizens interested in legislation related to public health advancement—that, in due course, in the year 1931, in San Francisco and Los Angeles, groups again organized spontaneously, with similar purposes, and still later, in 1933, to amalgamate and form the present "Public Health League of California." It is of this present League, its set-up and value, that comment is now made in the hope that other constituent state medical associations will consider the desirability of forming similar organizations. If such Leagues, once formed, would then make of themselves a Federation, they would give scientific medicine—nationally considered—a better opportunity than present political trends now permit, to maintain standards designed to best protect the health of the people of the United States.

* * *

Public Health Leagues Should Be Formed By All State Medical Associations.—It is the belief of many physicians, who have intimate affiliations with the work and needs of organized and scientific medicine, that until organizations or groups such as the Public Health League of California are brought into existence in the various States of the Union—the state groups, in turn, to form a national federation of their own, with similar purposes—progress in bringing about a change in the public's and legislators' reactions will be of only moderate amount. In other words, if more active steps are not taken, the American Medical Association, its constituent state associations, and the latter's component county medical societies will continue to lose prestige and power in the promotion of public health work and scientific medicine. Time, in all this, is of the essence.

The importance of the time element is emphasized in a recent article which appeared in the *Westchester Medical Bulletin* for November, published by the Medical Society of the County of Westchester, New York, and having the following title and subhead:

THE TIME IS NOW!

What Must Be Done If the Medical
Profession Is to Fulfill Its Fundamental
Obligation to the American People?—
A Plain Call to Action!

The *Westchester* article appears in this issue, on page 351.

* * *

There Is No Substitute.—In the August issue of CALIFORNIA AND WESTERN MEDICINE, on page 111, in comment on the Wagner-Murray-Dingell Bill and ways and means through which such legislation could be defeated, reference was made to the work of the Public Health League of California. For readers who may have missed the item, the concluding paragraphs, since they apply to what appears above, are here reprinted:

"It is all so evident. Members of the United States Congress will be glad to listen and act in proper manner when they know that a strong and influential group of constituent citizens is watching how their votes on public health matters are cast in the chambers of the Senate and House of Representatives.

---

[1] California League for the Conservation of Public Health: Its Purposes: "To spread wider and more accurate knowledge of what scientific medicine is doing and can do for the promotion of health, the prevention, control, and limitation of the various diseases; to counteract pernicious propaganda and warn the people of the dangers of quackery by presenting reliable information through Better Health, Better Health Service, and other proper channels of publicity; to encourage the enactment and enforcement of better health laws; to promote and maintain more and better hospitals wherein educated physicians may render better service to the people of California, is the constant constructive purpose of the League for the Conservation of Public Health."

[2] "In legislative matters and publicity the medical profession of California has set an example through the League for the Conservation of Public Health that other states may profitably follow. . . . There never was a time when so many people distrusted not merely physicians, but medical science itself. . . .We, in California, have to face anti-science in a very acute and belligerent form. The anti-vaccinationists would, if they could, reduce us to the sanitary methods of China, and various groups offer every possible legal obstacle to intelligent health administration. . . . The lack in most states of active medical leadership threatens an even more direct reaction on the profession. These problems cannot be escaped. If they are not faced by physicians, they will be faced by somebody else. . . . The public needs to be educated. If it were merely ignorant, it would not be so bad. Conscious ignorance looks up to knowledge. The trouble is that it has been so long miseducated.

"While legitimate medicine made itself a mystery, or wrapped itself in dignity, the quacks and the cults were busy. The people 'know too much that ain't so.' Their grandmothers mistaught them first, the quacks next, and now the cults. It is only recently that organized medicine has gone actively into the business of popularizing medical knowledge. Now by public lectures, by personal contact, and especially through the newspapers and magazines, much valuable work is being done—and none better than by the League for the Conservation of Public Health here in California. I am giving this well-merited compliment as a publisher, who is familiar with the various types of popular medical writers, and a journalist who has had some experience in writing for the public."—Chester H. Rowell.

"In other words, to be heard in the legislative halls in Washington the opinion is spreading here—no matter what other States do or do not do—California henceforth must keep in better touch with its Federal Senators and Congressmen.

"If in every State in the Union there existed an actively working organization such as the California Public Health League—whether under such a name and as a separate entity, or a similar set-up as an expression of a Committee on Legislation and Public Policy of a constituent state medical association, would make little difference—then the deplorable and pathetic situations which have been coming to the front with increasing frequency at Washington, D. C., would probably not have arisen.

"Let us keep in mind:

"The message that will have most weight in Washington will be that which comes from the Senator's and Congressman's own constituents.

"There is no substitute for this."

C. M. A. ANNUAL SESSION IN 1944 WILL BE HELD IN LOS ANGELES

Why Change of Place Was Made.—In the September issue of California and Western Medicine, it was stated that the Council, at its 312th meeting held on August 22, 1943, had voted to hold the 1944 annual session of the California Medical Association in the city of San Francisco. However, that city has become the major port of embarkation for troops and supplies to the Pacific War Zone, and hotel and like accommodations of that metropolitan center are even now more than overcrowded. In fact, much of its hotel space has been commandeered by Army and Navy for service to their respective personnels, and all available information indicates that hotel facilities for current civilian care will grow worse instead of better.

* * *

Los Angeles Will Be the Place of Meeting.—Wherefore, it has been found necessary to change the place of meeting from San Francisco to Los Angeles. Fortunately, the Hotel Biltmore in Los Angeles was held open for use by the California Medical Association several days during the first week of May.

The tentative dates for the two-day annual session will be Sunday and Monday, May 7-8, 1944, and Association headquarters will be at the Hotel Biltmore, Fifth and Olive streets, Los Angeles. Members who contemplate attendance should make reservations early, both with hotel and train or airplane companies. To be kept in mind, however, is the new rule that, after January 1, train reservations will probably not be made by railway agents for more than thirty days in advance. Members not resident in Los Angeles should remember that transportation facilities on the Pacific Coast are heavily strained, and that reservations for coming and going may not be available unless made well in advance.

The program arrangement of the 1944 annual session was outlined in the September issue, on page 155. Three general meetings will be held: Sunday morning, Sunday afternoon, and Monday morning. The thirteen scientific sections will hold their program and organization meetings on Monday afternoon. No meetings will be held on Monday evening.

Members who have papers in mind, or suggestions to offer concerning speakers or topics, are requested to write to the Association Secretary, who is the ex-officio chairman of the Committee on Scientific Work, or to the proper secretary of any of the thirteen scientific sections, whose names are listed in each issue, on advertising page 6.

MATERNITY-PEDIATRIC PROGRAM: IT LOSES NONE OF ITS IMPORTANCE

Why Discussion of the Maternity-Pediatric Program Is Continued.—Much space has been given in California and Western Medicine to comment and articles concerning the maternity-pediatric program put out by the United States Children's Bureau. Since the plan elaborated by the Washington authorities is of a nature that will work against maintenance of the best quality of maternity and pediatric service, and is also a real menace to public health and medical practice interests of the present, and as well of the future, the Official Journal can follow no other course than to acquaint physicians of California concerning developments as they arise.*

* * *

Facts to Keep in Mind.—In consideration of the subject, some facts must be kept in mind:

1. Congress has passed several appropriation bills designed to provide maternity and pediatric care to pregnant wives and to infants of enlisted men. With that basic objective all physicians and citizens are in accord, and the California Medical Association, with other state medical societies, has gone on record in approval.

2. Congress unfortunately, however, delegated to one of the offices in Washington (the Federal Children's Bureau of the United States Department of Labor) the authority to devise the manner in which the money so appropriated should be spent.

That Bureau works through its small inner circle at the Capital, but there is also, of course, the usual large hand-picked advisory committee for it to fall back on should occasion arise. Its advisory bureau consists of more than forty members, largely social workers and physicians; among the latter many who are full-time teaching specialists, but with about only one general practitioner in the entire committee.

In making known its plan for medical aid to wives and infants of enlisted men, the Federal Children's Bureau saw fit to promulgate—and with considerable success has inflicted on the medical profession in most States of the Union, for the work to be rendered—an arbitrary fee bill of $35 to $50 for the multitudinous services covering months of work. For the above gesture fees, a physician is obligated to give:

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* For additional comment in this issue, see page 342.

(*a*) All prenatal examinations and care, plus a Wassermann, urinalysis and hemoglobin report;

(*b*) All confinement services; and

(*c*) Postpartum care to mother and child, and a last visit at least six weeks after the confinement.

(Compare, but for contrast only, such service compensation as assigned to skilled professional men, to the high wages paid per day to unskilled laborers, or the rewards to manufacturing concerns, on cost-plus payments!)

* * *

Recent Visit of the Federal Children's Bureau Representative to California.—The story of the visit to California by Dr. Edwin F. Daily, director, Division of Health Service of the Federal Children's Bureau, and his conference with California Medical Association representatives in the office of the California State Board of Public Health has been set forth in previous issues of the OFFICIAL JOURNAL.

It was the privilege of the Editor, at the annual conference of State Association secretaries and editors held in the American Medical Association headquarters in Chicago on November 19 and 20, to inform that Conference, with Doctor Daily present, concerning the propositions put forth by Doctor Daily when he was in California, and the objections thereto which were made by Dr. Karl L. Schaupp, chairman of the California Medical Association committee on the maternity-pediatric program.

It is to be regretted that all members of the California Medical Association and physicians elsewhere could not have heard the statements made by Doctor Daily in San Francisco and Chicago. They were an illuminating example of what the medical and other professions, and businesses in general may expect when political and economic power can be expressed by edict.

* * *

Why Legitimate Criticism of the Federal Children's Bureau Is Handicapped.—Because of war conditions, and the ease with which a governmental bureau can now carry on a direct or indirect smear campaign—under the slogan of nonpatriotic coöperation—the members of the medical profession are at a distinct disadvantage in any public or press discussion of the procedures put forth by the Federal Children's Bureau. Witness, for instance, the Ohio experience (given on page 181 in CALIFORNIA AND WESTERN MEDICINE for September, 1943, Item XXII). That possibility, however, should not prevent us from expressing the truth as we understand it.

Thus far, California has escaped such newspaper publicity. But for how long, and against whom, and for what, no one can foretell.

Action of the California Medical Association Council.—Let us repeat: (*a*) The Council of the California Medical Association has approved the plan of adequate maternity and pediatric care for the wives and infants of enlisted men.

(*b*) It has disapproved the plan of procedure as put forth and placed in operation by the Federal Children's Bureau. That was as far as the Council's authority permitted it to go, other than to use its best endeavors to bring about a change in the Federal Children's Bureau regulations.

(*c*) It must not be forgotten that the California Medical Association Council has no authority to obligate the component county societies to follow a set plan of procedure in professional work. In matters like this, its powers are only advisory.

(*d*) The Council has informed the members of the California Medical Association that, in its opinion, each member of the California Medical Association is free to act for himself in this program.

That is:

He or she may sign the Federal Children's Bureau blanks and receive the stipulated fee of $50;

Or, sign but refuse payment for professional services from the Federal Children's Bureau or patient, in order to make the patient eligible to hospitalization service provided in the program;

Or, accept the woman desiring professional care, as a private patient, if such is the latter's desire, at a fee mutually agreeable between the patient and the attending physician.

* * *

A Pertinent Question.—At the present writing, what is the situation as it exists in California? And concerning the future, in what way may the unfortunate features of the Federal Children's Bureau plan be remedied?

Physicians throughout the United States are posing the question, "Why must a procedure so obnoxious as that put forth by the little circle that influences the Federal Children's Bureau be continued?"

To that pertinent query, the answer must be: The constituted authorities of the Federal Children's Bureau have given no indication that they will change the present arrangement. Indeed, at the Chicago Conference, to which reference has been made, Doctor Daily partly justified the Bureau's stand by stating that "Congress" had refused to change it. Doctor Daily evidently forgot that Congress consists of a Senate and a House of Representatives, and that the House of Representatives has a total of 435 members; and further, the vote to which he referred was a snap vote taken at a time when Congressmen had not yet been fully informed concerning the implications of the Federal Children's Bureau plan, with presumably only 123 members present or voting thereon.

* * *

Federal Children's Bureau Is Amenable to Congress in Expenditure of Public Funds.—To be kept in mind, also, are these facts: thus far Congress has found it necessary to make three different appropriations to carry on the work, the preliminary estimates of the Federal Children's Bureau having been found to be inadequate. (Appropriations were: $1,200,000; $4,400,000; and $18,620,000. See CALIFORNIA AND WESTERN MEDICINE, October 1943, on page 226.) These appropriations indicate that Congress will be called on to grant still further deficiency allocations. How soon such call may be made is not known. The increasing number of pregnancies will determine that.

In the meantime, if physicians throughout the United States—by action of their several state and county medical societies—will acquaint their respective Congressmen with the issues involved, it may be possible to bring into being specific instructions from Congress to the Federal Children's Bureau, making it mandatory upon the Federal Children's Bureau to offer a more equitable and reasonable set-up than that which is now being carried on. Presumably, that is the only way in which a rectification of the existing deplorable edicts may be remedied. The solution of the problem depends, therefore, upon national coöperation through the State and component county medical societies.

* * *

General Practitioners Should Be Added to the "Advisory Board of the Federal Children's Bureau."—On October 21, 1943, in Washington, D. C., the "Maternal and Child Health Advisory Committee" of the United States Children's Bureau held a meeting, the official minutes of which appeared in *The Journal of the American Medical Association* (November 27, on page 845). The last item, number 9, refers to a "recommendation" that "at least five general practitioners be added to the Advisory Committee."

As a matter of justice to the thousands of general practitioners who, in practice, will be called upon to carry through and do the obstetric-pediatric work, the addition of ten rather than five general practitioners, representing different sections of the country, would seem to be quite in order. Certainly, the present members of the Advisory Committee should not object. And if they did, on what grounds?

It will be interesting to note whether the Children's Bureau representatives (Miss Katherine Lenroot, chief; Dr. Martha M. Eliot, associate chief; and Dr. Edwin F. Daily, director, Division of Health Service) who were present at the last Advisory Board meeting of October 21 will have acted or so recommended when that Committee again convenes in Washington, D. C., at the meeting that has been called for December 10 to 11, 1943. The recommendation for five general practitioners was made at the October 21 meeting, but the official minutes gave no indication that action had been taken thereon up to November 23. Concerning that item and the session that since has been called, possibly more anon.

One half of the world knows not how the other half lives.

—George Herbert, *Jacula Prudentum.* (1640).

EDITORIAL COMMENT†

TYPES OF TETANUS TOXIN

Hitherto unsuspected qualitative differences between different preparations of tetanus toxins are reported by Friedemann[1] and his associates of the Brooklyn Jewish Hospital.

Seven tetanus toxins were bioassayed by the Brooklyn physicians, four of which were obtained from different American firms, and one from Germany. The minimal lethal dose was determined for each toxin by five different methods: (*a*) intraventricular injection into rabbits and guinea pigs, and (*b*) intramuscular injection into rabbits, guinea pigs, and mice. From data thus obtained the calculated titers of the toxins varied from 3,200 to 20 (intraventricular) M. L. D. per c.c. for rabbits and from 64,000 to 800 (intramuscular) M. L. D. per c.c. for guinea pigs. As a wholly unsuspected finding, the relative titers of the seven toxins varied with the animal species and method of testing. If the seven products were arranged (ABCDEFG) in a descending scale of toxicity for rabbits (intraventricular test), the order would be BACEDGF for ginea pigs (intramuscular test), and CAEBG (D and F not tested) for mice (intramuscular test).

The differences became even more apparent on comparing individual toxins. In rabbits (intraventricular test) toxin D, for example, is ten times more potent than toxin G. Tested by the intramuscular route in guinea pigs, however, G is only 60 per cent stronger than D. In rabbits, D is 100 times more potent by the intraventricular than by the intramuscular route, while the corresponding ratio is but 10:1 for toxin A. In guinea pigs, C is but twice the intramuscular titer of B, while it is eight times stronger in mice.

Further differences became apparent on determining the amount of antitoxin necessary to neutralize the different toxins, antitoxin prepared by the Bureau of Laboratories, New York City Department of Health being used in all tests. In order to simulate conditions of the natural disease, an "indirect" method of titration was adopted. A constant dose of tetanal toxin (20 intraventricular M. L. D. in the guinea pig and 10 M. L. D. in the rabbit) was injected into the intraventricular space, preceded by an intravenous injection of varying amounts of antitoxin. Control "direct" titrations were also made, the same dose of toxin being mixed *in vitro* with varying amounts of antitoxin and the mixtures injected intraventricularly. The two methods gave inconsistent results. By the "indirect" test in guinea pigs, toxin A required 100 times more antitoxin per unit for its neutralization than toxin F, and 64 times more than toxin E. On "direct" test, however, toxin A required but half the amount of antitoxin necessary for the neutralization of an equal dose of toxin E. By the "indirect" method in rabbits all seven toxins were neutralized by exactly the same volume of antitoxin, while in the "direct" tests in rabbits the antitoxin requirements varied for the individual toxins.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

These unsuspected results prove that, in addition to the currently recognized quantitative differences between different preparations of tetanus toxin, there are equally important qualitative differences. Whether or not these are due to different types of *Cl. tetani* has not yet been determined. The antitoxin titrations also show that there are hitherto unsuspected physiological factors that must be taken into account in antitoxin therapy.

Publication of additional data is promised for the near future.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

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SPREADING FACTOR IN SWINE INFLUENZA

In 1931, Shope[1] established that swine influenza is caused by the concerted action of two infectious agents, an ultravirus and a bacterium. While there is at present lack of evidence of a necessary bacterial component in interpandemic cases of human influenza,[2] data obtained in army camps in 1918 suggest that pandemic human influenza may possibly be of such duplex etiology. In anticipation of the next human pandemic, a simple technique for the study of virus-bacterial synergism has been developed by Bang[3] of the Rockefeller Institute, Princeton, New Jersey, based on the use of the nine-day chick embryo.

Burnet[4] and others had previously found that influenza virus placed on the chorioallantoic membrane of the chick embryo rarely gives rise to virus infection of the lungs and other underlying tissues. If the virus is injected through the chorioallantoic membrane into the amniotic fluid, however, the trachea, lungs and other underlying tissues are readily infected. Bang found that if a drop of virus filtrate is placed on this membrane, and if twenty-four to forty-eight hours later there is a superimposed infection with *H. influenza suis,* a rapidly fatal lung infection often develops. In one of his series there were but three fatalities among thirty-six control embryos infected with the virus alone and but five fatalities among an equal number infected with the bacillus alone. Among thirty-five chick embryos subjected to the combined inoculation, twenty-three (66 per cent) died. Histological studies showed that death was accompanied by a selective destruction of the embryo lung. Control tests showed that such destruction was not produced by either infectious agent acting separately.

Bacteriological studies revealed no influenza bacilli in the internal organs of the embryo. There was no demonstrable increase in the virus titer on the chorioallantoic membrane, but a high virus titer was demonstrable in the underlying amniotic fluid. The sole action of the bacteria, therefore, seemed to be due to a "spreading factor" facilitating penetration of the virus through the chorioallantoic membrane.

This interpretation of the nature of the virus-bacterium synergism is confirmed by the fact that filtered extracts of frozen, dried, or heat-killed *H. influenza suis* have the same synergic action. The filtrate retains its spreading power even after heating to 100 degrees centigrade for 30 minutes. Virus-spreading effects are also demonstrable when purified preparations of hyaluronidase are substituted for the Hemophilus filtrate. Hyaluronidase, however, does not cause a comparable increase in mortality. It seems probable that increased spread of the virus to the underlying tissues is only partly responsible for the mortality, and that other bacterial products play a rôle in chick mortality.

Bang's synergic theory and technique are of particular clinical promise, should occasion arise, to apply them to human pandemic influenza. Whether or not the Hemophilus "spreading factor" is antigenic has not yet been determined.

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MEDICAL EPONYM

Waldeyer's Ring

This was described by Professor H. Wilhelm G. Waldeyer (1836-1921) of Berlin at the meeting of the Berlin Society for Internal Medicine on May 5, 1884, in a paper entitled "Ueber den lymphatischen Apparat des Pharynx [The Lymphatic Apparatus of the Pharynx]." This was reported in abstract in the *Deutsche medicinische Wochenschrift* (10:313, 1884). A portion of the translation follows:

"Since the discovery of the pharyngeal tonsil by Lacauchie, the tubal tonsil by J. von Gerlach, and the establishment of the fact that the follicles of the tongue together represent a superficially spread-out tonsillar structure (the lingual tonsil), it is now evident that a ring of lymphatic tissue surrounds the whole region of the throat and upper pharynx, the course of which may be traced as follows: beginning with the pharyngeal tonsil, it extends to the region around the orifice of the eustachian tube (the tubal tonsil), thence to the faucial tonsil and down along the margin of the glossopalatine arch to the lingual tonsil, whence it crosses to the opposite side and follows a similar path back to the pharyngeal tonsil.

"The tonsils simply represent marked accumulations of lymphatic tissue, which is nowhere absent in the above-mentioned region, being demonstrable even in all the intertonsillar spaces. The investigations of the speaker show that the lymphatic tissue also extends deeply into the nares as the center of the middle and lower turbinates and downward onto the posterior wall of the pharynx. This ring of adenoid tissue may be termed 'tonsillar ring' or the 'lymphatic ring of the throat.'"—R. W. B., in *New England Journal of Medicine.*

ORIGINAL ARTICLES

Scientific and General

MEDICAL PRACTICE OF THE FUTURE: AS A MEDICAL ADMINISTRATOR VIEWS IT*

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PROBABLY there are a great many of you who do not have the time nor the inclination to concern yourselves with medical economics. With the increased load placed upon private practitioners of medicine because of the War, I am sure that most of you find little time for reading beyond that of a purely clinical nature. However, the problem of medical economics and the method of distributing medical care is, without a doubt, the most important problem facing the medical profession. Before further discussion of this subject, I should like to state that my views are those of a medical administrator and not a practicing physician.

I should like to discuss, first, health plans as operated and directed by industry. You are aware, I am sure, that there have been many and that they have been in existence for a great number of years. As examples, we have plans operated by Endicott-Johnson, Sears-Roebuck, Western Electric, National Cash Register, General Motors and, here in California, the Permanente Foundation.

PREPAID HEALTH INSURANCE

In considering prepaid health insurance of any kind, the following facts should be borne in mind: In the States of Washington and Oregon as early as 1930, county medical societies offered service on a prepayment basis. The California Physicians' Service was established in this State in 1939 as the first state-wide medical plan under the sponsorship and control of the medical profession. Since that time the States of Massachusetts, New Jersey, Pennsylvania, Delaware, North Carolina, Michigan, and Colorado have formed state-wide plans. At the present time, medical plans are operated by local medical societies in New York, Texas, and Washington. As of March 1, 1943, there were 800,000 subscribers to medical plans in the twelve states operating such plans. In the State of Michigan alone, over 440,000 citizens have medical coverage. This evidence should adequately refute the statement that physicians were kicked out of medical societies, in most instances, because they had participated in prepayment medical care. In addition to the medical service coverage, there were over 12,500,000 people having Blue Cross hospital coverage and over 5,000,000 having hospital coverage from commercial insurance companies.

As you all know, health programs, operated by industry in the main, envision a prepayment program with physicians on a salary, practicing as a group with a hospital as the center, under the management of industry. The following quotation from Mr. Kaiser, taken from Dr. de Kruif's book, "Kaiser Wakes the Doctor," indicates his program: "Will the manufacturers now dare to organize, finance and manage medical centers in every industrial community, where medical service could be purchased on an insurance basis at a cost which would bring not only the skill and facilities, but all the advantages of research within the reach of the common man?"

Indicating his idea for one source of supply of doctors for a salaried program, de Kruif, in his book, gives credence to an opinion I do not share when he says: "Immediately postwar, there'd be scores of thousands of young physicians coming back to civil life who'd had a taste of group medical care, of giving the most scientific medical care to millions, with no consideration of the cost of it—and on salaries which made their own lives secure." My personal experience indicates to me that the greater portion of the physicians in the military service are there to do their patriotic duty under a régime of military discipline, and are willing to be regimented for the duration. The great need which allows them to accept this regimentation in no way means their acceptance of it for a lifetime.

ATTITUDE OF THE MEDICAL PROFESSION

Physicians, in general, do not object to spreading the cost of medical care of the few among the many. Nor do they believe in monopolistic control of the healing power; but they do feel that, because of the complicated nature of medical practice, it should remain in the hands of the physicians, and that such physicians should become trustees or guardians for the public of this great human necessity which ranks with the other two great needs of food and shelter.

Much of the printed material and many of the radio broadcasts today fail to point out that medicine in America is at one of the highest levels of any place in the world and that it is the earnest desire of physicians to maintain that level—and continue to raise it—for the benefit of the public and not for their own personal gains, as has been so many times indicated.

One author has indicated that, as soon as a health plan had started and got under way, people stopped dying. The reader is left with the inference that, because of the plan, the death rate had been greatly reduced. In all fairness to medicine as it has developed in America today, it should be pointed out that the death rate from pulmonary tuberculosis in 1912 was 125 per 100,000 estimated population, in 1920 it dropped to 97, and in 1938 it had dropped to 44.6. In twenty-six years the rate had dropped to about one-third of the original. It should also be noted that the infant mortality rate in 1916 was 101 per 1,000 live births, in 1930 it had dropped to 64.6, and in 1940 it had dropped to 47. The foregoing sets of figures, which may be demonstrated in other diseases, indicate that progress has been made in medicine and that it may be expected to continue.

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* One of the addresses in a symposium given at the 75th Anniversary San Francisco County Medical Society November 7, 1943.

It is very unfortunate that the people who have read the 15,000 printed copies of de Kruif's book could not have the same knowledge and background that the men and women of the medical world have. Handling facts very loosely, de Kruif refers to the 40 per cent of our boys who have been rejected from the draft, a large part of them physical wrecks, because they never did have decent medical care. He fails, however, to point out that a large percentage of these young men have been physically disqualified because of poor vision and flat feet, which are in no way going to be affected by prepaid medical service or early medical care.

DE KRUIF-KAISER PROPOSITIONS

De Kruif brings his book* to a conclusion with the following description of Mr. Kaiser's vision: "The medical mercy of these workshops can now rapidly wipe out the curse of syphilis. It can cut the present death toll from cancer by more than one-third. It can begin to conquer the rheumatic heartwreck that saps the strength of hundreds of thousands of our young people, the heartbreak that yearly kills them to the number of 40,000. It can abolish the misery and the insanity of women's change of life. By the skilled use of the new powerful hormones, it can extend the sexual activity and lengthen the vigorous prime of life of men, so that we will no longer say that we grow old too quick and wise too late. It will abolish the prostate gland misery that makes so many old men social outcasts. It will wipe out tuberculosis with a speed that will frighten the executives of the National Tuberculosis Association. This new group medical mercy will sound the death knell of still murderous lobar pneumonia and will remove the strength-sapping infection of gonorrhea from men and its maiming curse from women. In the new health centers our physicians and chemists will uncover and correct the widespread chemical hidden hunger, the vitamin starvation that gnaws the nation's nerves and weakens its muscles. Here, too, the new shock therapy will be turned against early mental sickness—to rob our asylums of hundreds of thousands of their tragic victims. Practicing physicians will co-work with eye specialists to check the blindness of glaucoma in its beginning. With all science instantly available, the doctors of these new hospitals will cut the death and maiming of newborn babies to a low that will excite the envy of Dr. Herman N. Bundesen—greatest of all fighters for the lives of children. And this community group prepaid medicine, freeing doctors from economic pressure, will cut down the pitiful toll of maiming, and of death, that exists because of surgery that is remunerative first and curative afterward." I wonder if Mr. Kaiser's vision includes the attracting of the right type of person to the medical profession; the assurance of a good medical education, the establishment of good hospital residencies; the stimulation of active, never-ending research; or whether it will develop more scientifically trained, emotionally endowed authors.

Kaiser, in his program, points to great profits which are bound to accrue in the operation of medical centers and he proposes that such profits be redirected into the enlargement and improvement of medical facilities throughout the country. Why should such altruism apply to profits derived from health care when history reveals to us that profits derived from industry did not establish protective guards for dangerous machinery, clean and comfortable rest rooms, lunch-room facilities, reasonable working hours, sick-leave benefits, vacation periods, retirement plans, and compensation for industrial accidents, until such time as legislative action occurred? What assurance do we have that the operation of health centers by industry with the employment of salaried doctors will not open up another field for corporate profits? In summarizing my remarks on the Kaiser type of medicine, I should like to point out to you that his plan is not new. That his idea of spreading the cost is not new. That his program is experimental and much too young to warrant a 158-page biography. That his health program at the time of de Kruif's book did not include the women and children in his Richmond yards. That, in comparison with other medical centers and hospitals, his program is far from complete, since he does not operate a nurses' training school, a school for dietitians, a residency and fellowship program, laboratories for experimentation, the training of physical therapists, nor does his program give a history, because of its youth, of any developments toward the improvement of medical care. Many of the problems, paramount among which is the matter of crowding, may be seen daily at the Permanente Foundation Hospital in Oakland. Three beds frequently occupy the space allotted to two. This is not unusual and not unjustified in our present situation.

I have no quarrel with Mr. Kaiser regarding the medical plan which applies to his shipyards; nor with his medical staff who are products of the same type of medical schools from which both you and I have graduated. However, I do have, and believe you also will have, a violent objection to Paul de Kruif's description of the Permanente Foundation which, by inference, leaves the reader with a vivid picture of every private practitioner as a medical Shylock prescribing x-rays only for the annointed, vitamins only for the shipbuilding industrialists, and with hospitals reluctantly admitting the ill and throwing them out on the sidewalk long before they are well.

WHAT THE PUBLIC SHOULD KNOW

I wish that it were possible for the medical profession to get across to the public:

1. That nearly all physicians throughout the country agree, and always have, with Mr. Kaiser's desire to bring to our citizens the best and most adequate diagnostic facilities and early medical care.

2. That thousands of physicians throughout the country have taken part, and are taking part, in prepayment medical programs in an attempt to bring this care to the public.

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* For review of de Kruif's book, see October issue of California and Western Medicine, on pages 207 and 244.

3. That thousands of physicians throughout the country have no quarrel with Mr. Kaiser regarding his wartime program, but they do not share his ideas for postwar medicine under the management of industry.

4. That in a profession where it is desirable to approach, as nearly as possible, an exact science, publicity of an emotional nature is not desirable.

5. That medical conservatism in diagnostic and therapeutic measures, as well as methods of distribution, have saved the American public much suffering, many heartaches, and much money.

6. That a medical plan, a hospital scheme, beautiful institutions, and shining laboratories would be of no avail were it not for the well-trained, emotionally stable physician. The public should know now, more than ever before, that its medical care will only be of value if directed by the hands and minds of well-trained physicians.

7. That the American physician is not as selfish as he has been pictured, and the great majority of the medical profession, even though they have a personal interest in their activities, are anxious that the profession be guarded and carried on for the benefit of the public, at its present high level.

8. That the prepayment health service, of the type operated by industry, does not allow the free choice of physician and the free choice of hospital. This particular point has always been felt to be of utmost importance in any health care program.

9. That, while American medicine costs well over $2,000,000,000 per year, the American public also spends for the luxury items of tobacco, cosmetics, and liquors a sum which amounts to about $5,000,000,000 per year.

GOVERNMENTAL APPROACHES ON HEALTH CARE: WAGNER S. 1161

Now, let us turn from the industrial approach to the private practice of medicine; to the governmental attempt to encompass this field. This governmental approach crystallized itself in Senate Bill 1161, which was introduced to the Seventy-eight Congress in its first session by Mr. Wagner of New York. This bill, frequently referred to as the Wagner-Murray-Dingell bill, proposes an amendment to the existing Social Security Act and includes, among other things, to establish a federal system of medical and hospital benefits; to encourage and aid the advancement of knowledge and skill in the provision of health service and in the prevention of sickness, disability, and premature deaths. This new bill would impose a tax of 6 per cent on the wages of all individuals earning up to $3,000 per year and a similar tax of 6 per cent upon the employer. A self-employed individual may obtain the benefits under this proposal, if it becomes law, upon the payment of a tax of 7 per cent on the market value of his services up to $3,000 per year. Hospitalization benefits under this program shall be a maximum number of thirty days, placing the authority with the Surgeon-General to extend this coverage to ninety days for the following calendar year, provided the funds are adequate.

The operation of this program, in its clinical aspects, is placed in the hands of the Surgeon-General of the Public Health Service, empowering him to enter into contractual arrangements with physicians and hospitals. All financial arrangements are left under the control of the Social Security Board, who will authorize all expenditures from the trust fund established by the above taxation. The Surgeon-General will have an advisory medical and hospital council to consist of the Surgeon-General, as chairman, and sixteen members to be appointed by him. It should be carefully noted that this council is to be advisory only and without power, thereby depending entirely upon the integrity of each surgeon general to accept and value the Council's advice. Such members shall be selected from panels of names submitted by the professional and other agencies and organizations concerned with medical service and education and with the operation of hospitals, and from among other persons, agencies or organizations informed on the need for or provision of medical, hospital or related services and benefits. The Surgeon-General will also establish fee schedules, qualifications for specialists, determine the number of individuals for whom any physician may provide service and determine what hospitals or clinics may provide service for patients. In all the above matters, the Surgeon-General may be advised by the Advisory Council. Payments to physicians may be made on any of the following four bases: According to a fee schedule approved by the Surgeon-General; on a per capita basis—the amount varying according to the number of individuals on physicians' lists; on a salary basis—whole or part time—or a combination or modification of these bases as approved by the Surgeon-General.

Section 912 of the bill further provides that the Surgeon-General and Social Security Board jointly shall have the duty of studying and making recommendations as to the most effective methods of providing dental, nursing and other needed benefits not already provided under this title. This bill covers ninety pages and was introduced by Mr. Wagner on June 3, and referred to the Committee on Finance. For those of you who have time, I should strongly urge getting a copy of this bill and reading it. Without further detail regarding provisions of this bill, I should like to discuss it in general.

VIEWS OF CHAIRMAN OF UNITED STATES SOCIAL SECURITY BOARD

Many things may be, from time to time, read into this legislation if it is passed. Perhaps it might be well to review some of the attitudes of the Social Security Board as voiced by Mr. Altmeyer, its chairman. He envisages the hospital as the center of coördinated services for the well and for the sick—a community center for prevention as well as diagnosis and cure. Mr. Altmeyer states that the whole cost of hospital care as a potential community service falls upon the one family out of four or five who, in the course of a year, uses that service and that the cost of hospital care must be distributed among groups of people and over periods of time. When approached with the statement that in one decade over 12,000,000 people have been covered with Blue Cross Hospital Service, he states: "Ten times as many are outside these voluntary prepayment plans. Indifference and lack of foresight are barriers which cannot be hurdled by voluntary selling." Unfortunately, the indifference and lack of foresight which Mr. Altmeyer described cannot be denied on the part of some of our physicians and some of our hospitals.

However, thousands of our physicians appreciate the need for spreading the cost of medical care for a segment of the population and their participation in prepayment plans, similar to the California Physicians' Service, is tangible evidence of this appreciation. The public should be made aware of this. Also, many physicians value close association with hospitals and feel the value of centering medical activities there. The public should be made aware of this, but these same physicians feel that this close association may be effected and still retain their identity as individuals with free right of action. The public should know this. Where hospitals are strategically located, facilities for doctors' offices should be encouraged. But in the meantime the public should know that many large downtown and uptown doctors' office buildings now house, nearly in complete form, diagnostic facilities in one building, with the close association of many doctors.

We continually hear repeated the fact that the Federal Government has no intention of disturbing private voluntary effort, even under the provisions of the Wagner bill. Mr. Altmeyer states, in referring to voluntary hospitals: "These institutions have been the mainstay of general hospital service. More so in this country than elsewhere. They have been and are a notable expression of community action and community service; a symbol of fellowship and compassion among our people. The social insurance proposals for hospital benefits offer no threat to the voluntary hospitals. There is nothing in the proposals which proposes or intends that the social insurance system shall interfere with hospital operations or invade the field of hospital administration properly reserved to the individual institutions." One is immediately reminded of the old adage that "He who pays the fiddler calls the tune." Can it be possible that this adage, which has stood the test of time, will no longer be true?

VETERANS' ADMINISTRATION PROGRAM: ITS RECORD

I believe that this is a particularly good time to consider the history of federal hospitalization and to review the Veterans' Administration Program which was created by an Act of Congress on October 6, 1917, authorizing the medical treatment of persons disabled in World War I. It was the first legislation of this type in our national history. Following the close of World War I, there were 251,916 disabled service men discharged from the service. Medical care to this group was furnished, in the beginning, by the U. S. Public Health Service in the twenty marine hospitals and the Tuberculosis Sanitarium at Fort Stanton, New Mexico. In addition to this, the Surgeon-General took over eight hospitals in Army cantonments and contracted for the utilization of several hundred civilian hospitals. By June of 1920, fifty-two federal hospitals were being used with a bed capacity of 11,639 and there were 26,850 available beds in civilian contract hospitals; a total reservoir of 38,489 beds. Brigadier General Frank T. Hines, Administrator of Veterans' Affairs, in a speech at Buffalo, New York, in September, 1943, stated that, because the type of service afforded in a number of civilian contract hospitals was not satisfactory, the Secretary of the Treasury, in his report, criticized the situation, with the result that on March 4, 1921, $18,600,000 was appropriated by Congress. That again, on April 20, 1922, $17,000,000—making a total of $35,600,000—was appropriated for the erection of permanent federal hospitals. By 1924 there were forty-four federal hospitals operating 26,000 beds.

In April, 1922, Congress authorized hospital treatment for diseases or injuries not war connected for veterans of the Spanish-American War, the Philippine Insurrection, and the Boxer Rebellion. On June 7, 1924, Congress passed an act which assumed that all tuberculosis and psychiatric conditions occurring before January 1, 1925—six years after the Armistice—to be military connected. At this time there were a number of empty beds in the forty-four federal hospitals, and Congress, therefore, authorized the acceptance of all veterans for hospital care to the limit of empty beds, whether the condition was service connected or not. On March 20, 1933, the benefits for non-service connected injuries were repealed, but in the following year, on March 29, 1934, all such benefits were reinstated.

By June 30, 1937, the Veterans' Administration was operating 81 hospitals in 43 states with 47,420 beds, plus 2,159 beds in other federal hospitals. From 1919 until 1936, $149,222,000 have been appropriated by Congress for new hospitals, domiciliary and out-patient facilities and, in addition, $23,478,000 had been expended from regular fiscal funds for permanent improvements and extensions. On May 8, 1940, the President approved a ten-year program to enlarge bed capacities to 100,000. In the early part of 1942, because of the declaration of war, this was accelerated so that, at the present time, there are now being operated by the Veterans' Administration, ninety-three hospitals with 61,770 beds.

I am sure you are all familiar with the system of practicing medicine under the program of the Veterans' Administration, and I would bring to your attention the fact that with a potential ten million persons connected with the military service, the medical program for the veterans of World War II will make the program I have just described appear miniature. This is particularly true when one reads the following excerpt from General Hines' speech: "Whereas, in World War I less than 35,000 women served as army or navy nurses, yeomanettes, and marinettes, and thereby earned such entitlement, the Veterans' Administration will now be concerned with several hundred thousand women, who will be potentially eligible for hospital treatment not only for diseases or injuries resulting from service in the armed forces, but for any intercurrent conditions (other than pregnancy or parturition) that may develop during their lives." I am sure that you agree with me that we want the very best medical program available for the veterans of this war, but I am also sure you will agree that neither the veterans nor the physicians are entirely in accord as to the best method of furnishing such medical care. Any discussion or planning of postwar medical care which does not take into consideration the medical care of the veterans of World War II will be unrealistic.

UNITED STATES PUBLIC HEALTH SERVICE AND HEALTH PLANS

I should personally be very much happier, if we must have federalized medicine, to which thesis I do not concur, if such a program in its entirety were formulated, administered and governed by the trained physicians of the United States Public Health Service. It is quite evident to me, from the public utterances of the chairman of the Social Security Board and the Surgeon-General of the Public Health Service, that a background of medical education plays a great part in medical planning. The following are a few statements made by Doctor Parran in his recent talk: "Lack of capacity to buy our service should not deprive anyone of the best. The total cost is well within the individual and collective ability of the population to pay." Such a statement certainly allows for private enterprise to do the job on a prepaid basis. Doctor Parran further states: "Among the poorer classes of our population, infant mortality is highest, expectancy of life is lowest, the amount of sickness is greatest and, in particular, the rates of such preventable diseases as tuberculosis and syphilis are most prevalent. In this country, death rates for these groups have been progressively downward, but there is a shocking disparity between geographic as well as economic groups." I believe that Doctor Parran, in such statements, indicates much more factually than does the chairman of the Social Security Board or certain popular authors, that private medicine has done a job in many areas. I am sure that we will agree with the Surgeon-General that in poverty-stricken areas, medical service is not adequate, and I hope, too, that he will agree with us that a plan for the entire country need not be patterned to meet the needs of the poverty-stricken areas. Doctor Parran, later in his talk, lays down the challenge to American medicine in the postwar world with the following statements: "Recent developments make it possible within a few years after the War and at moderate costs, to locate every case of tuberculosis in the population. The malaria-control authorities tell me that if we were to develop our present controlling forces, we can anticipate the substantial eradication of malaria in this country within another decade. One-third of our cancer deaths are preventable if we were to provide for all people in all parts of the country the modern facilities for diagnosis and treatment now available to a few." Doctor Parran leaves the way open for private medicine to do the major portion of the necessary health program which seems to be a different attitude than that taken by the chairman of the Social Security Board, who indicates that compulsory health insurance is the only way to meet our needs. To quote Doctor Parran: "I believe there will be a growing sentiment for extending the prepayment principle through compulsory insurance or otherwise, to include the hazards of illness."

During the past several years, we have continually heard philosophy broached that the hospital should be the center of all medical activity. Doctor Parran expresses the same idea: "I am convinced that increasingly, as medical science grows and grows more complex, it can be applied for the people's use with increasing effectiveness through groups of physicians working together. . . ."

I am sure you all realize that there are several methods by which centering of medical activities may be developed at the hospital. However, there is fear of regimentation beyond the War period in a thought expressed by Doctor Parran as follows: "Perhaps the Procurement and Assignment Service could go into reverse and become a placement service."

When one thinks of the many medical school graduates whose residency programs have been disrupted because of their induction into the military service, it is encouraging to know that the Surgeon-General has expressed the hope that the training plans which the President has announced for men on demobilization will include such young doctors. Doctor Parran summarized his recent talk in a vein which I believe demonstrates the value of a medical background as contrasted with that of certain lay bureaucrats when he says: "If any of the pending proposals are unfounded, the professions concerned should formulate better ones. It is necessary that we should be for something better than we have had in the past. We have the knowledge, we need only determination and a will to find acceptable ways of utilizing it fully for all."

I personally believe that it is a sad commentary that a stronger relationship has not existed between the United States Public Health Service and the private physician of the United States. We have in Washington, in this service, men who have attended the same medical schools that we have. Certain of their views may differ from private medicine, but at least we have a common background and through the Public Health Service, from time to time, I am sure we could avail ourselves of the governmental ear to further and direct programs which we feel are beneficial to American health.

AMERICAN MEDICAL ASSOCIATION: ITS ACTIVITIES AND MEDICAL ECONOMICS

Now, let us look at the American Medical Association and its interest in this problem of medical economics over the past fifteen years. It would be impossible, in the short time allotted to this part of our program this afternoon, to review in detail all the information found in the minutes of the House of Delegates and other publications of the American Medical Association. But I shall attempt, nevertheless, to sketch briefly some of the points which occurred from year to year.

As early as 1928 President Jackson at Minneapolis recommended a council of medical economics. In Portland, Oregon, July 1929, President-Elect Harris discussed the cost of medical care. We find as early as August, 1929, in the *Canadian Medical Association Journal,* a recommendation by Mr. McCullough that a state system of health sickness insurance, including an improved public health service, is desirable.

At the meeting held at Detroit, Michigan, in 1930, President M. L. Harris brought the attention of the delegates to the fact that during the year the Public Medical Service Association of England has been formed for the purpose of establishing universal medical service. Later on in his report he enunciated the fundamental principles proposed by the chairman of the Committee on the Costs of Medical Care, which were unanimously adopted by the General Committee with slight verbal changes: (1) The personal relation between physician and patient must be preserved in any effective system of medical service. (2) The concept of medical service of the community should include a systematic and intensive use of preventive measures in private practice and effective support of preventive measures in public health work. (3) The medical service of the community should include the necessary facilities for adequate diagnosis and treatment.

At the Detroit meeting, Dr. J. B. Harris of California introduced a resolution requesting the consideration of the House in forming a council on medical economics. The purpose of this council to be (1) to investigate conditions of medical economics and to suggest means and methods by which the same may be improved; (2) to endeavor to further the realization of such suggestions as may be approved by the House of Delegates. Both resolutions were referred to a Reference Committee.

It is also interesting to note that in June of 1930 *The Journal of the American Medical Association* carried a report that sick-benefit insurance had been adopted in France.

In July of 1930 the Reference Committee on reports of officers endorsed the work of the Committee on Costs of Medical Care and unanimously approved the principle involved in the recommendation of the California Medical Association in the suggestion for the Bureau of Medical Economics.

In June, 1931, at Philadelphia, President-Elect E. Starr Judd reports that the Bureau of Medical Economics is just being organized and ultimately will have all available information regarding the cost of medical care.

COMMITTEE ON COSTS OF MEDICAL CARE

In December of 1932, an editorial in *The Journal of the American Medical Association* carries a reference to the report of the Committee on the Costs of Medical Care. Significant in this report is the recommendation of the minority group of the Committee: "The minority recommends that the corporate practice of medicine financed through intermediary agencies be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained high quality of medical care or unfair exploitation of the medical profession." It is very evident from this abstract that there was no unanimity of thinking regarding this epoch-making report. Reading the report of this Committee on the Costs of Medical Care which appeared in *The Journal of the American Medical Association,* December 3, 1932, page 1954, in the light of our 1943 experience, allows one to appreciate the evolutionary processes which have gone on during the past eleven years.

In July of 1933, a committee on medical economics in its report recommends that the investigation of group hospitalization be continued and that the results of the study be published.

In May of 1934, prior to the meeting of that year, the Bureau of Medical Economics indicated that considerable stress is laid on the tendency of insurance to increase lay control of medical service and to show that this is a universal policy of the insurance administrators and of advocates of insurance in this country; and they also report that there is no definite connection for or against insurance further than to make it clear that existing systems of insurance have failed to solve the problem of medical care.

In June, 1934, at the Cleveland session, a special committee reported, among other things, that it is a well-known fact that voluntary insurance has always been the forerunner of compulsory insurance, and even the most ardent advocates of voluntary insurance admit that fact.

In a special session of the House of Delegates, Febluary, 1935, the attitude of the National Association toward voluntary insurance and toward compulsory insurance was reaffirmed.

CALIFORNIA AND SICKNESS INSURANCE

By May of 1935 there were five columns of *The Journal of the American Medical Association* given over to an article by the editor, entitled "California and Sickness Insurance." It is evident in this article that at the time much thinking was going on regarding health insurance and that the American Medical Association was not in accord with the actions of the Council of the California Medical Association.

In 1937, in June, at the Atlantic City session, a resolution was introduced by Dr. Samuel J. Kopetsky of New York, outlining principles, proposals, and recommendations regarding the development of a national health program. The comparison of certain principles and proposals in this resolution to the present Wagner bill are of interest in retrospect. The same year, Doctor Vohs of Missouri introduced a resolution recommending the establishment of a council on medical ethics and economics, stating that compulsory health insurance was under consideration by the Federal Government and that he felt much education was needed on the part of the physician. We find that the same session introduced a resolution by Doctor Stone of Ohio on the matter of group hospitalization raising again the question of what should be excluded from such programs and reaffirms the problem as to the definition of hospital service and medical service.

At the Atlantic City session in 1937 a Committee on Legislative Activities pointed out that the recent decision of the Supreme Court, which validated most of the Social Security Act, would open up an avenue for new legislation which could involve the profession of medicine. The Committee felt that the attitude of the medical men throughout the United States would determine such a step. Here we have, just six years later, the introduction of the Wagner bill as an amendment to the Social Security Act, including medical and hospital service.

In the reports of officers in April of 1939, the Bureau of Medical Economics devoted thirteen columns in the Association's journal to a discussion of medical service, hospital service, relations between doctors and hospitals, and related subjects, which indicated great activity on the part of the Bureau during that year.

In June, 1941, a resolution was presented by Dr. Harry Wilson of California, requesting the appointment of a committee to confer with the American Hospital Association and the Catholic Hospital Association. The Reference Committee on Legislation and Public Relations stated that the extra work thrown on the administrative offices of the organization by court procedures and by the medical preparedness program, has made it well-nigh impossible to make a careful study and report covering the subject matter involved in Dr. Harry Wilson's resolution.

The report of the Bureau of Medical Economics on April 15, 1942, stated the following: "No valid reason has been advanced to show that medical service organizations and group hospital plans cannot function separately as parallel services in communities that are sufficiently interested to support such efforts."

SUMMARY REGARDING AMERICAN MEDICAL ASSOCIATION OPINION

It is evident, in the review of fifteen years' minutes of the House of Delegates of the American Medical Association: (1) That there is no unanimity of thinking among physicians regarding medical and hospital coverage either on a governmental basis or on a private basis. This leads one to wonder whether the actions of the House of Delegates and the Board of Trustees of this Association reflect medical thinking in this country. (2) That there has been constant effort year after year, as evidenced by the introduction of resolutions, to try to bring about the culmination of efforts to establish ways and means of bringing health care to that segment of the population who have difficulty in purchasing it. (3) That studies and recommendations of the Committee on Costs of Medical Care remain, to a great extent, historical data. (4) That there is a lack of rapport between American medicine and American hospitalization. It seems unbelievable that private medical and hospital programs can succeed in meeting the problem and either retain their voluntary status without a better understanding and greater teamwork.

COMMENTS ON AMERICAN MEDICAL ASSOCIATION POLICIES

One is led to realize that much, too much, of the activities of the American Medical Association are attempted to be carried out by the voluntary efforts of the House of Delegates year after year. The changing of such delegates and the lack of continuity and contact throughout the years have failed to accomplish continued progressive and straight-line thinking.

When one realizes that the budget of the American Medical Association, as of April 24, 1943, is listed at $1,644,820.96, one cannot but wonder why it has been necessary to maintain to such an extent the *status quo* attitude. Surely, with a budget of this size, more progress might have been expected each year, during the past fifteen years, which would, in the aggregate, build up an answer to the inroads of government. Unfortunately, our public relations program, or lack of program, throughout the country has resulted in adverse criticism of the physician. American medicine needs now, and has needed for years, active positive leadership rather than passive negative leadership.

While we may not have a concrete proposal to meet the suggestions of the Wagner bill on hand, it rests within our province to develop such a program with the active participating support of America's hundred and fifty thousand physicians. The Bureau of Medical Economics, composed of twelve full-time employees on June 1, 1940, has dwindled to five today; at a time when their efforts are needed more than ever before. A reëstablishment of this Bureau and an increase in its personnel should be accomplished by the central office.

The public should know that the American Medical Association, as an organized national body, has contributed immeasurably to the public health and welfare. Its Council on Medical Education and Hospitals has left its imprint on American medicine. Its Council on Pharmacy and Chemistry has been the watchdog and guardian of American pharmaceuticals and the constant advisor to the physician on new medicinal products. Its underwriting program of the archives of the various specialties has given a medium for the dissemination of sound medical knowledge. Its annual scientific exhibits have brought together material of immense value to the physician. Its Bureau of Medical Economics has contributed much to our knowledge during its short existence. Its weekly journal has carried to America's physicians, even in the smallest hamlets, reports and discussions on medical problems which have allowed the American citizens in the smallest communities to benefit by medical experiences in other parts of the country.

PROS AND CONS ON SYSTEMS OF MEDICAL PRACTICE

There are certain thoughts in which I believe both the antagonist and protagonist of any system of medicine will agree:

1. There is a segment of the population which does not know how to secure the medical care that is available to it.

2. There is a vast difference between medical needs and medical demands.

3. For employed individuals earning $3,000 a year or less, some type of prepayment health plan whereby the cost of medical care may be spread is desirable.

4. Hospital facilities need much attention. The existing facilities can stand considerable improvement and alterations to meet present needs. Many rural communities need the addition of hospital facility.

5. The constant presence of a medical staff in and around a hospital may have benefits to the patient and to the physician.

6. There is a growing feeling, not only on the part of the public, but also on the part of some of the medical profession, that the American Medical Association must take more positive action on a national basis than it has in practical methods of distributing medical care more widely.

7. There is a lack of confidence on the part of the physician in a type of Government-controlled medicine.

8. There is lacking satisfactory coöperation between hospitals and physicians on a national level.

9. There is an alleged lack of confidence on the part of the public in organized medicine.

10. There is a real lack of public education in medical practice as it exists.

11. The American public in general still desires free choice of doctor and free choice of hospital when ill.

12. Much greater emphasis should be placed upon the correction of basic conditions which are closely related to ill health. Food, housing, transportation, and employment, if properly planned for in the postwar world, may reduce medical needs considerably.

ON POSTWAR INVENTORIES CONCERNING MEDICAL PRACTICE

I believe that, being faced with postwar health problems, it behooves the medical profession to take inventory of the above thoughts and attempt to determine the truthfulness and the extent to which the above beliefs exist. I believe that we, as physicians, must carry on not only in the postwar world, but during the remaining years of the war, a better public education program which will bring home to the public the tremendous job the medical profession has done. We must get across to them that we have evidence to believe that the American system of medicine is the finest that exists in any part of the world; that we realize, as the physicians of California have demonstrated, the need for a prepaid program for certain segments of the population. The public should be made aware of the fact that the administration, stimulation and continuation of our present system of American medicine, will only go on if those men who are most fitted to insure its existence—namely, the physicians who have brought it to this level—continue to direct its destinies.

From the years 1932 to 1942 in San Francisco alone, there were 5,449,699 out-patient visits to the out-patient departments of this city and no one has written a book about it. From 1932 to 1942 there were hospitalized in our city and county hospital 158,307 patients for 4,119,755 days. The above figures demonstrate service rendered by the private physicians of this community on a voluntary basis without remuneration, and no one has written a book about it. There are today nearly 13 million people covered with group hospital service, and no one has written a book about it. Nearly one-third of our physicians have left their homes and private practices to enter the military service, and the remaining two-thirds of the private practitioners in this country, men in most instances who, because of the military selection, are in the older groups, are now carrying the entire load of medical practice. These men have given up their peacetime privileges and pleasures—and no one has written a book about it. During the past year we have had several large disasters; the one receiving the greatest publicity being that of the Coconut Grove fire in Boston, where 491 people lost their lives and a great many more were injured. Within a two-hour period, 114 were taken to one hospital alone. In this institution, as in many others, the physician, who has been depicted as a medical Shylock, gave his services unstintingly for the unfortunate victims, and in one institution in Boston no fees were charged for any of the hospital service rendered to the disaster victims, and no one has written a book about it. The American medical profession, both in its horse and buggy days and in its present form, has contributed endless hours without remuneration in the care of unfortunates, both in their offices and in hospital clinics. They have also spent endless hours and great sums of their own private money for research which has frequently netted them nothing but discouragement; yet, we know this must go on—but no one has written a book about it. I personally believe that the greatest job facing the American medical profession at the present time is a public relations program based on factual data and free from emotionalism. The American public must know the story if they wish to preserve that which we think is valuable. Of the 135 million people in the United States, only about 150,000 are physicians. We cannot, by any stretch of the imagination, represent a monopoly. The American people must decide what they wish and we shall be compelled to do their bidding; but our responsibility rests in educating that American public as to what they have and what they may give up under a new system.

DECISIONS EVERY PHYSICIAN SHOULD MAKE

Every physician should decide which of the following systems he wants:

1. A completely federalized system for all Americans with part of the puppet strings pulled by the United States Public Health Service and part by a lay Social Security Board.

2. A system owned, financed and operated by industry which may rise and fall with Dow-Jones averages.

3. A system directed and guided by physicians, including county or federal care for the indigent, applying the prepaid principle to the lower brackets and allowing the doctor to charge a private fee to others.

4. A system directed and guided by commercial insurance companies, or

5. A system that remains *status quo* and sings its theme song of "stand-patism."

I should like to make the following recommendations, to which I claim no originality:

RECOMMENDATIONS: IN RELATION TO NATIONAL NEEDS

1. A full-time resident representative with diplomatic experience in Washington.

2. Whole-hearted coöperation with the United States Public Health Service.

3. Whole-hearted coöperation of the American Hospital Association and the American Medical Association.

4. A definite stand by the American Medical Association for prepaid health insurance on a voluntary basis.

5. Establishment of a Medical Service Plan Commission within the American Medical Association to collect and pool the experience of the constituent state societies regarding prepaid medical service.

6. Employment of more full-time personnel for study of voluntary health insurance with reëstablishment and expansion of the Bureau of Medical Economics.

7. A public relations program which will win back for the physicians as a whole greater respect from the public and which will change the opinion toward the American Medical Association from that of a monopolistic body to one of guardianship and trusteeship of America's most sacred need—medical care.

8. A review of the studies of the Committee on the Costs of Medical Care in the light of the Wagner bill.

9. Expenditure of as much time in studying methods of distribution of medical care as we have spent in the improvement of medical care.

RECOMMENDATIONS: IN RELATION TO CALIFORNIA'S NEEDS

1. Formation of a state-wide nonprofit hospital service plan in accordance with the recommendations of the Mannix survey.

2. Stimulation of greater interest on the part of the physician in California Physicians' Service.

3. Amalgamation of administrative and enrollment programs for the state-wide hospital and medical service plans.

4. Continuation of the coöperation which now exists between the California Medical Association and the California State Department of Public Health.

5. Coöperation of physicians and hospitals with the Procurement and Assignment Service of the War Manpower Commission and other governmental agencies in the prosecution of the war.

6. Continuation of interest and study in the methods of distributing medical care in California.

Lane Hospital, Clay and Webster Streets.

MEDICAL PRACTICE: ITS EVOLUTION*

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During the three years following World War I, more people died from famine and preventable disease than lost their lives in the War itself. Already a half-dozen uncoördinated agencies of the Federal Government are dealing with the various phases of the problems related to health that are likely to become prominent in the postwar period.

The building of hospitals, the redistribution of physicians, the prevention of disease, the promotion of health, the development of health centers, the determination of nutritional deficiencies, the rehabilitation of medical material and equipment, and the distribution of trained scientific personnel, are among the activities related to health which demand study and for which there must be planning. Even now a half-dozen governmental agencies are actually competing with one another for the available medical personnel and the available medical supplies. In the postwar period such competition, under uncontrolled conditions, might well be ruinous.

If there is one need outstanding at this time it is the establishment of an overall governmental agency to which would come the demands for medical personnel, medical supplies, hospitals and hospital equipment or other medical needs. From such an agency allocation or recommendations might be made on the basis of exact knowledge or inventory such as is now kept by the Procurement and Assignment Service for Physicians as to the availability of physicians, and by the War Production Board as to the availability of materials. Such an agency would equally be in a position to advise the President, the Congress, or the individual bureaus of the Federal Government as to medical necessities and the possibilities of meeting the existing needs. From the very nature of its work such an agency would include in its membership not only the medical profession, but leaders in the fields of public health, education, and the production of medical materials.

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* From the office of the editor of *The Journal of the American Medical Association* and *Hygiea*.

Abstract of one of the addresses in a symposium given at the 75th Anniversary, San Francisco County Medical Society, November 7, 1943.

ACHIEVEMENTS OF AMERICAN MEDICINE

The progress of medicine in the United States has been one of the phenomena of the last century. Today the world as a whole recognizes the achievements of American medicine. Only last week there came from Great Britain, in a letter from the British Council, one of the most important planning organizations in that country, a recognition of American leadership in scientific medical bibliography and librarianship. N. Howard Jones, director of the Medical Department of the British Council, spoke of "the considerable respect that many of us here have not only for American medical literature, but for the remarkable lead that America has given to the rest of the world in everything pertaining to medical bibliography and medical librarianship."

The standards of medical education in the United States have been steadily raised since 1905, so that today the medical colleges of our country are not only on a par with, but probably superior, to most institutions devoted to medical education elsewhere in the world. Our hospitals as a group have also become noted for the quality of the service that they render.

The health of the nation as a whole is indicated by the continuously decreasing rates for death and for illness, so that in 1942 both the death rate and the morbidity rate of the nation were the lowest in our history. It may be too much to claim that this superiority is the result of the basic principles that prevail in the organization of public health and medical practice in this country. It would be the height of folly to insist that they could be wholly separated from the organization of the medical profession, the system that underlies the organization of public health administration, and the basic principles of medical practice formulated in the Principles of Ethics of the American Medical Association.

EVOLUTION OF MEDICAL SERVICE

Since the establishment of the American Medical Association in 1847, almost one hundred years ago, the methods of administration and distribution of medical service have been undergoing continuous evolution, coördinated with the continuous advancement of medical science. Whenever a new discovery has been made for the prevention or treatment of disease, it has been incorporated into medical practice and into public health procedure. Thus, improvements in anesthesia, in the use of the x-ray, in laboratory techniques for diagnosis, in inoculation against infectious disease, in the administration of oxygen, of the sulfonamides or penicillin, or insulin for diabetes, are promptly reflected in medical practice.

True, there is a lag between the development of a technique or method and the time when it becomes the property of all physicians. Yet even this lag is, in the United States, far shorter than similar lags elsewhere in the world.

The evolution that has gone forward has taken on increased intensity since the end of World War I. Those who have participated in the advance of medicine for thirty years, as I have, know that proposals to revolutionize the nature of medical practice of the United States began to be made seriously in 1911 and 1912 when Great Britain adopted its system of compulsory sickness insurance. It will be remembered that the British medical profession resisted to its utmost the establishment of compulsory sickness insurance by the Lloyd George government, and that it failed to prevent the enactment of the British National Insurance Act. However, that Act has been, since that time, limited largely in its effects to persons with incomes under $1,200 per family per year, for whom it provides only general practitioner service such as the doctor may render in his office or in his home. It does not cover dependents, nor does it cover specialistic or hospital service.

Almost every year during the last thirty there has been introduced into the Congress of the United States legislation which would tend to compulsory sickness insurance for the American people, either in part or as a whole. Such legislation has failed of enactment. When the Social Security Act became effective in 1934, an attempt was made to include compulsory sickness insurance as the third arm of security, but at that time compulsory sickness insurance was eliminated, and funds were greatly increased for work in the field of preventive medicine under the United States Public Health Service and the Bureau of Maternal and Infant Welfare of the United States Department of Labor.

Subsequently, in 1937, a National Health Conference was held and Senator Wagner of New York introduced Bill No. 1620, which would have provided a nation-wide system of compulsory sickness insurance. Hearings were held on that proposal before the Senate Subcommittee on Education and Labor, under Senator Murray of Montana, and that proposal died when the Congress which would have considered it ceased to function.

Now comes a new proposal to expand the Social Security Act. This includes as one of its provisions a section which would put the American people under a compulsory sickness insurance provision and which would indeed place all of medicine under the Surgeon-General of the United States Public Health Service. Such a proposal, embodied in the so-called Wagner-Murray-Dingell bill, would be in every sense of the word, revolutionary.

Medicine never hesitates to use radical measures when required in a desperate situation. However, there is no evidence that the health of the people of the United States is at this time in any way in a desperate situation. Indeed, every phase of medical development in this country testifies to the soundness of the progress that has been made and indicates the desirability of continued evolution rather than revolution.

Especially serious among the proposals of the Wagner-Murray-Dingell bill is that portion which would give to a federal agency complete control of medical education. Should that activity become effective, the Surgeon-General of the United States Public Health Service would make grants-in-aid to such institutions as he thinks "show promise of making valuable contributions to the education or training of persons useful to or needed in the furnishing of medical, hospital, disability, rehabilitation, and related benefits provided under this Act or to human knowledge with respect to the cause, prevention, mitigation, or methods of diagnosis and treatment of disease and disability."

Such political control of medical education would inevitably destroy the standards of excellence that now characterize the medical schools in America. How long would it be before the selection of medical students would become the function of political influence rather than the voluntary standards of today, which depend on methods of selecting students with regard to high personal qualifications and ethical integrity of the medical profession?

Indeed, a careful study of the Wagner-Murray-Dingell bill shows that its drafters focused their attention much more on the political machine for controlling and distributing medical service than they did on the quality of the service itself. Medical care is a service given by physicians. The ability to diagnose and treat disease and to protect the health of the public depends on the qualifications of the physician—on his education and training, his integrity, his skill, and his initiative. With such qualities the Wagner-Murray-Dingell bill is little concerned.

In the United States, during the past fifteen years the private practice of medicine has been supplemented and in many places substituted by new techniques for providing medical care. Already some thirteen millions of people are covered by insurance against the costs of hospitalization through the so-called Blue Cross plans, industrial group insurance, fraternal hospital insurance, and in other ways. Many large industries have provided systems of complete medical care for their employees. Still more arrange to meet the costs of catastrophic surgical and medical conditions.

Under these plans the patient may utilize the service of his own doctor or a specialist selected by his doctor, or of groups of physicians organized in a variety of ways. The groups of doctors who render service are sometimes organized as employees of a corporation, sometimes as partners in a corporation, sometimes as the employees of educational institutions.

There are plans for distribution of medical service under prepayment techniques organized by various communities, by farm groups, by governmental agencies, and by industries. Most of these plans differ today from what they were when they were first organized. They are still undergoing active evolution.

There is much misunderstanding of the relationship of the American Medical Association to these proposals. The American Medical Association has accepted the principle of insurance against the hazards and costs of sickness. However, medical leadership does not encourage politics in medical care and is, in general, inclined to local rather than federal control.

Notwithstanding much that has been said to the contrary, there has never been opposition to the practice of medicine by groups of physicians. There has been opposition to certain methods used by such groups which tend to deteriorate the quality of the service and make the cost in fees considerable. Underbidding by groups of physicians for the medical care of employees of certain industries, house-to-house solicitation of patients and similar practices are fought by the medical profession, not with a view to protecting the physician or his fee for service, but primarily because such practices lead to deterioration in the nature of medical service that is rendered.

When assumption *B* of the Beveridge plan was placed before the British Medical Association by the Ministry of Health, arrangements were made to summon the representative committees of that body and for them to present their recommendations to the representative body of the British Medical Association, which is similar to our House of Delegates. That representative body has just concluded a series of principles underlying the plan by which medical service would evolve in Great Britain. The basic principles are essentially the same as those which were adopted as the platform of the American Medical Association several years ago. Moreover, the secretary of the British Medical Association has recently published his views, and has used as the title for his address the slogan that we submitted in 1932, *"Evolution not Revolution."*

In several of its proposals the British Medical Association states the philosophy of health service so clearly that they cannot be improved on. Thus, they emphasize the importance of preventive medicine, the desirability that the general practitioner be the mainstay in medical service, that laboratory facilities and consultants be available, and that there be coördination between the various agencies concerned with medical care.

Then they say: "The health of the people depends primarily upon the social and environmental conditions under which they live and work, upon security against fear and want, upon nutritional standards, upon educational facilities, and upon the facilities for exercise and leisure. The improvement and extension of measures to satisfy these needs should precede or accompany any future organization of medical services.

"The efficiency of a country's medical services, both preventive and curative, depends upon the available medical and scientific knowledge, upon the character and extent of medical education, upon the sufficiency and quality of personnel, upon facilities for treatment and upon the absence of any economic barriers that impede the utilization of such services. Thus, in order to improve the country's medical services, the facilities and resources for medical research should be greatly increased and methods devised for their adequate application; medical education, both undergraduate and postgraduate, should be maintained on a high standard and be adapted to modern needs; there should be sufficiency of personnel and institutional accommodation; and wherever economic barriers prevent an individual taking advantage of medical services such barriers should be removed."

Next, the representative body stated that the functions of the state should be to coördinate existing provision, to augment it where necessary, and control economic barriers to good medical service.

The platform of the American Medical Association calls for:

"The establishment of an agency of federal government under which shall be coördinated and administered all medical and health functions of the Federal Government exclusive of those of the Army and Navy.

"The allotment of such funds as the Congress can make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need."

Indeed, the American Medical Association has heartily approved the provision of medical care for the indigent and the medically indigent with determination of need, and local control of administration.

This proposal for utilization of federal funds is far different from the erection of a federal mechanism involving the expenditure of $4,000,000,000 annually, such as is proposed in the Wagner-Murray-Dingell bill.

The American Medical Association has proposed as the seventh tenet in its platform:

"The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability."

The representative body of the British Medical Association has said that it is not in the public interest that the state should convert the medical profession into a salaried branch of central or local government service; that it is not in the public interest that the state should invade the doctor-patient relationship, and, finally, there should be initiated, by arrangement and agreement between the government and the profession, organized experiments in the methods of practice, such as group practice, including health centers of different kinds which should extend to general practitioner hospital units attached to general hospitals. Future developments in group practice should depend upon the results of such clinical and administrative experimentation.

Thus, without the slightest consultation or interchange of opinion other than appears in the medical press of the two nations, the British medical profession and ours are in agreement as to the trend which the evolution of medical practice should follow.

We, in this country, have already begun many experiments with and without the aid of the Government. Mr. Henry Kaiser's industrial plan is evidence of the manner in which experimentation may be undertaken, but time alone can indicate the evolution which that plan will follow to meet changing economic situations. Even the kind of group practice utilized by the Mayo, Lahey, and Crile Clinics, not to mention the Shadid and Ross-Loos Clinics, undergoes constant changing. It would be folly to offer any one of these experiments in the light of present conditions as the system to be followed by the entire nation.

No doubt, the plan utilized by the Farm Security Administration for giving medical care to 105,000 farm families has virtues, but even that plan has been modified from county to county, and from state to state.

Many a great organization, such as Sears-Roebuck, Western Electric Company, Endicott-Johnson Shoe Company, and, indeed, the headquarters of the American Medical Association, utilizes the services of the well-established insurance companies like the Metropolitan, New York Life, Travelers', Aetna, etc., to provide hospitalization, or sickness, or catastrophic insurance for its employees.

Fourteen state medical societies have erected plans whereby such organizations coöperate in extending hospitalization and sickness insurance to groups of workers who care to coöperate.

Medicine has not been static, neither has there been discouragement from professional medicine beyond what is needed to protect the public against those who see in the administration of medical service an unusual opportunity for exploitation because of appeal to a man in his time of greatest need.

535 North Dearborn Street.

OBSERVATIONS OF A MEDICAL OFFICER IN THE SOUTH PACIFIC AREA*

Colonel Frank G. Crandall, Jr.†
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FOREWORD.—In the spring of 1942 I was ordered to report to a West Coast port of embarkation for overseas duty. I was placed in command of a Medical Unit with a large staff of medical officers, dental officers, nurses, and trained enlisted medical technicians. We sailed to an unknown destination. By the end of the first day out many of the staff were seasick and so did not enjoy any part of the voyage. Day after day we zigzagged across the broad Pacific, and as the temperature went higher and higher we decided we were headed for some place in the South Pacific area.

Old King Neptune held his royal court aboard ship the day we crossed the Equator, and the very amusing ceremonies incident to making us all "shell-backs" and initiating us into the "Ancient Order of the Deep" required several hours.

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* Read before the annual meeting of the Oregon State Medical Society, Portland, Oregon, September 4-5, 1943.

The opinions and assertions contained herein are the private ones of the writer and are not to be used as official or reflecting the view of the Army Department or the Army service at large.

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Fire drills, boat drills, and "abandon ship" drills were held at frequent intervals throughout the entire voyage, and the ship was completely blacked-out after sundown. When we neared our destination we presumably were attacked by a Japanese submarine, which was sunk by our naval escort vessels with cannon fire and depth bombs. This, of course, was the most exciting part of our voyage.

After several weeks of sailing, during which land was never sighted, we finally arrived at the South Pacific island which was to be our headquarters. Since we were the first American troops to arrive in that part of the world, the natives gave us a very warm welcome.

As I was Senior Army Medical Officer in that area, I was asked to work with the Naval Surgeon on the staff of the area commander. In that capacity I assisted in developing the medical plans for the supply, evacuation and hospitalization of the wounded from the Solomon Islands combat area. Medical plans were also developed for other islands in the South Pacific area. It was my privilege to work in close coöperation with the Bureau of Medicine and Surgery of our Navy Department throughout my service in the South Pacific area from May, 1942 to January, 1943, and its representatives were very coöperative at all times.

RECORD OF A SOUTH PACIFIC AREA COMBAT ZONE

Some of the finest medical units of the Army and Navy were stationed in that area during this period. As an example of the fine work which these units accomplished, the mortality rate was less than 0.2 per cent for all wounded who were evacuated from Guadalcanal to base hospitals. A Navy hospital ship evacuated thousands of casualties from Guadalcanal to hospitals where I was located, and the mortality was only seven, or a rate of 0.17 per cent. In fact, the mortality rate for all the United States forces in all combat zones since the beginning of this war has been only about one per cent. This sounds so low as to be almost unbelieveable, when it is remembered that our mortality rate in World War I averaged between 7 and 8 per cent. There are many thousands and tens of thousands of American boys who will survive this war who would have died under the same circumstances during the last war.

There are three principal causes for this wonderful record. First, the use of blood plasma to combat shock and hemorrhage. Second, the use of sulfonamides to combat infection. And third, the speed and organization of the medical services so that prompt, efficient medical and surgical treatment is rendered, and the patients are hospitalized without delay.

In World War II the Army and Navy Medical Corps are so well organized that a wounded man is given life-saving medical and surgical treatment almost as soon as he is wounded. A very large percentage of the seriously wounded marines, sailors, and soldiers from Guadalcanal were flown back in transport planes to Army hospitals and advance naval mobile hospitals, where they were given the finest hospital care within a few hours after they were wounded.

The Army and Navy transport surgeons who evacuated wounded men on transports deserve a great deal of credit for the low mortality rate, as do the staffs of Navy hospital ships. Many of the casualties who arrived on these ships had been so well cared for by the surgeons on the ships that when they arrived back at hospitals in the rear they were out of danger and needed only bed care for a few weeks to convalesce.

ABDOMINAL WOUNDS

In the last war, 70 to 80 per cent of the men who suffered wounds of the abdomen and who lived long enough to reach hospitals in the rear died there. But in this war our mortality rate on these cases has been less than 5 per cent. Of course, a great many serious wounds of the head, chest, abdomen, and spine result in death on the battlefield before evacuation can be effected. But many of these wounded are saved by speedy evacuation, who would have been lost in the last war.

In the last war we lost, from wounds, 14,014 men who had been evacuated to hospitals in the rear. Most of these men could have been saved if we had had plasma, sulfonamides, and speedy evacuation.

The general use of tetanus toxoid as a prophylactic for all members of the armed forces has made tetanus almost an unknown disease in this war.

In this war every soldier, sailor, and marine who goes into combat is equipped with a small kit containing sulfathiazole tablets to be taken orally if wounded, and also five grams of sulfathiazole crystals to be sprinkled into their wounds. Of the severely wounded who reached the hospitals at Pearl Harbor, even those with terrible burns, the mortality was less than 3 per cent. At Guadalcanal it was less than 0.2 per cent.

In our experience in the South Pacific area it was found that by the use of microcrystalline sulfathiazole sprinkled directly into the wound, and the use of sulfonamides orally, infection was reduced to such a remarkable extent that radical debridement was not necessary, and that the wounds could be left open and light dressings placed on them without extensive suturing or frequent dressings being necessary. Patients thus treated had rapid uneventful recoveries in so many instances that it seemed miraculous. The only cases in which the sulfonamides did not seem to produce these results were those who had been wounded while fighting in isolated areas, and were thus delayed in receiving treatment so that infection with pus had set in. Fortunately there were very few of such cases.

FRACTURES

In compound comminuted, as well as simple fractures, we used the method developed by Orr of Lincoln, Nebraska, and employed so successfully by Trueta in the Spanish Civil War, consisting of rest to the fractured area and the application of plaster casts which were left on for several weeks. By this method the wound is scrubbed with soap and water, all dead tissues and foreign bodies are removed, sulfonamides are applied directly to the wound and it is packed wide open with vaseline-soaked gauze. Later the arm or leg is placed in a wet plaster bandage. The plaster is not changed for at least three or four weeks, and only then when the odor becomes unbearable. Thus, the patient is not subjected to painful, frequent re-dressings. When the dressing is removed from these fracture cases, in practically all instances the fracture has healed and no infection is present.

The history given by many of the sailors who have been blown into the water or whose ships have been sunk is that they spent twelve to sixteen hours or longer in the water before being rescued. Many of them had severe compound fractures and burns on which the warm sea water seemed to act in a beneficial manner.

During World War I, of all fracture cases in the United States Army, 40 per cent were permanently disabled and 12 per cent died. Those who were permanently disabled were chiefly so affected by amputation. On the basis of our experience in the South Pacific area, there will be less than 10 per cent permanently disabled and the mortality will be less than one per cent.

EVACUATION PLAN

Our plan for evacuation in the South Pacific area was to have first-aid men with the troops who carried morphine syrettes for use in relieving pain immediately. Our jeeps were constructed to carry two or four litters. Wherever it was possible for them to travel, they were used to transport the wounded from the battlefield to the battalion aid stations directly behind the lines where the casualties were given first aid, including morphine, sulphonamides, bandages, and splints. From the first-aid stations they were evacuated to the collecting stations, where further first aid was given, including blood plasma. From the collecting stations, ambulances transported them to clearing stations which were usually from three to five miles behind the lines. At the clearing stations, emergency surgery was performed if necessary, and from there the casualties were sent to base hospitals by ambulance, plane, or transport. Most of the seriously wounded from Guadalcanal were flown by plane to advance base hospitals.

BURNS

Burns are treated by the use of four grams of sulphadiazine orally, morphine, boric acid ointment or vaseline, pressure bandages and splints on the extremities. After this first-aid treatment they are given blood plasma, more sulphadiazine, debridement of the blisters and removal of loose shreds. Boric acid ointment dressings are applied. Other methods employed tannic acid and silver nitrate solutions sprayed on areas except the face, hands and genitalia, or the triple aniline dye spray. The Pickerell sulphodiazine spray treatment was also used in some cases. The results obtained from these various methods were very good, and the mortality was comparatively low.

TROPICAL DISEASES

In addition to the treatment of wounds, one of our greatest problems in the South Pacific Area was protecting our troops from and treating them for the prevalent tropical diseases of that area. Malaria and dysentery were our two greatest problems. Malaria is by far the most serious disease with which we have to contend in the South Pacific. We are using suppressive medication routinely on all troops going into the malarial areas of the South Pacific. This treatment is not a true prophylactic, as it only suppresses the disease and, upon discontinuance, a large proportion of the troops develop symptoms that must be treated with quinine, atabrine, or plasmochin. It is estimated that the number of deaths from malaria throughout the world is eight million per year, and 95 per cent or more of the native populations in a great many islands in the South Pacific area where we have troops, are infected with malaria. No matter what sanitary and other control measures are taken in regard to the immediate surroundings of our troops to eliminate mosquitoes, including the use of head nets and mosquito nets for sleeping, it is still necessary for combat troops to be exposed to mosquitoes at night. Mosquitoes will travel long distances after biting an infected person.

The anopheles mosquito is present in California, Oregon, and Washington, and thousands of veterans of the South Pacific and Southwest Pacific are being returned to Army and Navy hospitals on this coast for treatment, in addition to the men who are being discharged for physical disabilities. Therefore, a potentially dangerous situation exists in that many of these men will be infected with malaria and have recurrent attacks for many years. The Anopheles mosquitoes will, in turn, become infected from these men and probably infect the civilian population. The Army and Navy are cognizant of this situation and are taking steps to try to control it.

It will be recalled that the former boxer, Barney Ross, who was a marine in Guadalcanal and returned to this country to make public appearances, was required repeatedly to go to bed with chills and fever, and cancel his schedules because of recurrent malaria attacks.

Bacillary and amebic dysentery are also major problems in the South Pacific area. Bacillary dysentery, particularly, is a problem, due to the fact that on the tropical islands flies are so prevalent and carry the infection from infected feces to food. The best treatment for bacillary dysentery is rest and sulfaguanidine, and more recently it has been found that succinyl-sulphathiazole treatment is even much more effective.

Next in order of importance is dengue fever, which has incapacitated many troops for periods of a week to ten days or longer. There are other diseases of lesser importance, of which only a few cases have been reported, such as yaws, leishmaniasis, schistosomiasis and filariasis or elephantiasis (tropical diseases in which worms are present in the intestines and lymph glands). An interesting fact about yaws is that on islands where the native population is infected with this disease, there is no syphilis. One major problem has been the large number of cases of tropical sores or ulcers which have occurred in troops who have suffered abrasions to the skin from going through the jungle brush, or from swimming and coming in contact with sharp coral. These ulcers are very difficult to heal and become, in some cases, large, deep craters, causing disability for twelve to sixteen weeks. Some of our troops have developed a serious otitis of the external auditory canal from a fungus which entered the ear while swimming in the tropical sea water.

When thousands of service men are returned to the United States following their service in the South Pacific area, many of whom will have had these tropical diseases, it behooves every physician to study the clinical symptoms, diagnosis, and treatment of tropical conditions so that he may better recognize and treat them in the postwar period.

NEUROPSYCHIATRIC CONDITIONS

Neuropsychiatric conditions are an even greater problem in this war than in the last one. This is particularly true of the South Pacific area, where combat conditions in the jungles are probably worse than in any other place in the world. The humid heat, the constant rains, the mosquitoes and ever-present flies, along with the stench and filth of the foxholes and the constant bombing, shelling and strafing by the enemy, together with the maiming and deaths of their comrades, are conditions which a percentage of our troops cannot long withstand. This problem involves all branches of the service. Technically there is not supposed to be any such thing as war psychosis. However, we have come to the belief that every man has his breaking point if put under severe enough physical and mental strain. In civilian life an individual who has a few of the ordinary complexes or phobias avoids and sidesteps all the unpleasant situations and thereby avoids developing an acute psychosis. The same individual in the armed forces in the combat zone cannot avoid any of the terrible realities and horrors of modern warfare. After a certain amount of this he breaks and develops an anxiety neurosis, or what was called in the last war, "shell shock." We call it "combat fatigue" in this war. It may affect anyone and no one is immune. I have seen many of our officers and men suffering from it in the South Pacific. Some of them were medical and dental officers.

The Army and Navy Medical Corps are now both recognizing these cases of "combat fatigue" in their early stages and sending the patients back to rest camps in the rear before the symptoms become acute. Proper sedation and psychotherapy and rest aid in returning nearly all these patients to combat duty in a short time, with complete recovery.

While overseas I became seriously ill and after being hospitalized there for some time, was sent back to the United States for further hospitalization. On the return trip to this country, when we were in the middle of the Pacific, over 4,500 miles from home, the Navy warned us by radio that a Japanese submarine had been sighted and was trailing us at a speed estimated to be approximately the same as ours. We put on all available speed and prayed that the submarine would not catch up with us. You all remember that popular song of a few years ago, "California, Here I Come." Well, that was our theme song for the rest of the trip. You have heard how thrilling the Statue of Liberty looks to Americans returning from Europe. The Golden Gate Bridge looked just as wonderful to all of us as we passed under it and inside the harbor. It was a grand and glorious feeling!

Gentlemen of the Oregon State Medical Society, it has been my privilege to spend nine months in the combat zone of the South Pacific area as an Army medical officer, and I want to say to you that you, as physicians, have every reason to be proud and envious of your fellow physicians who are with the armed forces in that area. When this war is over and all the history of the various branches of the service can be told, you will find that the Medical Corps of both the Army and Navy have made an enviable record, and will have had as much to do with the final victory over the Axis forces as any other branch of the service. It is entirely possible that without their wonderful and efficient service this war could not have been won. We should all be proud of our profession.

Station Hospital, Camp Abbot, Oregon.

MEDICAL EPONYM

Adie Syndrome

This was discussed by William John Adie (1886-1935) in an article entitled "Pseudo-Argyll Robertson Pupils with Absent Tendon Reflexes, a Benign Disorder Simulating Tabes Dorsalis," which appeared in the *British Medical Journal* (1:928-930, 1931). He writes:

"I wish to draw attention to a benign symptomless disorder characterized by pupils which react on accommodation but not to light, and by absent tendon reflexes.

"Five of the six cases I am about to describe came under my notice in the course of a few weeks; the condition, therefore, cannot be very rare. Though harmless in itself, it merits recognition because it is often mistaken for a manifestation of syphilis of the nervous system, with unfortunate consequences for the patients and their families. . . .

" . . . The true Argyll Robertson pupil reacts promptly and fully, often excessively, on convergence, and dilates again as soon as the effort to converge the visual axes is relaxed. In these cases the pupils show the so-called myotonic reactions; they do not respond to light; they contract very slowly through a wide range during a sustained effort to converge; often remain small long after the effort ends, and, when they dilate again, do so slowly.

"It seems to me more than probable that some . . . cases with nonluetic Argyll Robertson pupils but normal tendon reflexes are examples of a milder form of the same benign disorder that I have described here."—R. W. B., in *New England Journal of Medicine.*

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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PRO PATRIA

ROSTER OF MEMBERS OF THE CALIFORNIA MEDICAL ASSOCIATION WHO ARE OFFICERS IN THE MEDICAL CORPS OF ARMED SERVICES

Upon request by the editor, the rosters of military members which follow were sent to CALIFORNIA AND WESTERN MEDICINE by the county society secretaries, to whom thanks are extended.

I

Alameda County Medical Association

Members of the Alameda County Medical Association on active duty with the Army and Navy.

(Report as of September 28, 1943. Total Number, 166.)

Name	*Rank* (if known)	*Service* (if known)
Abbett, A. L.		——
Adams, John Payson	Lieut.	Navy
Allington, Herman Vogt		Navy
Anderson, LeGrande		——
Armstrong, James R.		——
Atkinson, Ray C.		Army
Barnard, Leonard Bryan		Army
Barr, James Adam		Navy
Barron, Gilbert		——
Baxter, Philip N.	Major	Army
Bell, Dudley Philip		Army
Berkove, Alfred Ben		Army
Blosser, John A.		——
Blume, Frederick Elmer		Army
Boe, Max Richard		Navy
Boles, Albert	Captain	Navy
Borson, Harry J.		——
Buckley, Thomas Ignatius		Army
Burnham, Clark James, Jr.		——
Cameron, Lester		Navy
Campbell, James Valentine		Navy
Carpenter, Harold Clinton		——
Carson, A. Bradford	Lieut.	Army
Casey, Earle Addison		Army
Casey, Homer A.		Army
Chew, William B.		——
Church, Claude H.	Lt. Col.	Army
Cieri, Salvatore		Army
Cochran, George Vrooman		Army
Cocks, Charles Edward, Jr.		——
Crenshaw, Gerald LaVerne		Navy
Cronenwett, Paul H.		Army
Crum, Rolland A.		——
Davis, Andrew S.		Army
Davis, Stanley		——
Desch, William D.	1st Lieut.	Army
Dorius, Glenn Rees		Army
Dyke, Louis H., Jr.	Lt. Comdr.	Navy
Ellis, John Malcolm		Army
Ellwood, Paul Murdock		Navy
Epstein, Ervin Harold		——
Everingham, Sumner	Lt. Col.	Army
Ewer, John Norton		——
Fisher, Fred D.		Army
Fletcher, Elmer G.	Captain	Army
Foree, Lynn		——

[†] For complete roster of officers, see advertising pages 2, 4, and 6.

Name	Rank (if known)	Service (if known)
Frug, James		——
Furbush, Claude G.	Captain	Army
Garron, Levon K.		Army
Gleason, A. Lawrence		Navy
Gompertz, J. L.		Army
Graeser, J. B.		Navy
Grau, E. C.	Captain	Army
Gray, Gerald H.	Lt. Comdr.	Navy
Greenwood, Charles Frederick		——
Gump, Millard		Army
Hackley, R. W.		——
Hadden, Malcolm Backus		——
Hart, Melvin G.		——
Henry, John Robertson		——
Hills, C. B.		Navy
Holcomb, William F.	Lt. Comdr.	Navy
Hollingsworth, John B.		Navy
Horwitz, Harry		——
Hoyt, Werner Fletcher		Navy
Humphrey, Wendell H.		Navy
Hunnicutt, Arthur J.	Captain	Army
Hunt, Carson E.		Army
Irvine, George Samuel		Navy
Jenkins, Kenneth B.		——
Jensen, Oliver Brinton		Navy
Jenson, Herman H.	Lt. Comdr.	Navy
Johnson, Chester Frederick		——
Kaven, Henry A.		Navy
Kay, J. Harold	Lieut.	Navy
Kelley, Harry W.		——
Kenney, Eugene William		Army
Kimball, H. Stewart		——
Krueger, Albert Paul	Comdr.	Navy
Lake, Thomas Owens		——
Lamb, Woodburn K.		——
Larkey, Jefferson		Navy
Larkin, John C., Jr.		——
Leet, Robert S.		Navy
Legge, Robert Farjeon	Lt. Comdr.	Navy
Lewis, Julius		——
Lewis, Reinard B.		——
Loe, Harris D.		Army
MacDonald, James L.		——
MacCracken, William B.		——
Mainwaring, George F.		Navy
Maloney, Edward S.		——
Manley, Donald James		——
Mannerstedt, Godon		Army
Marriott, Joseph Lemaure		——
Matzinger, Philip		——
Mauser, Carl Louis		——
McCarthy, William Dennis		Navy
McChesney, Paul		Army
McCleave, Thomas Crooke, Jr.		Navy
McLeod, Kenneth C.		Army
Mell, Charles Newell		——
Michael, Paul P. E.	Comdr.	Navy
Miles, Robert H.		Army
Murphy, John Matthew		——
Nelson, Roy Frank		Navy
Nesche, George Elwood		Navy
Novy, Frederick G., Jr.	Lt. Comdr.	Navy
Ohanneson, John		Navy
Padden, Edmund H.	Major	Army
Page, Warren E.		Army
Parker, Fenton Ben		——
Patton, Henry		——
Pebley, Roscoe Sherman		Navy
Peers, Robert S.	Captain	Army
Peery, Leslie T.		Army
Perkins, William A.		Army
Perlmutter, H. A.		Army
Pier, Harry McKay		——
Pletta, Frederick A.		Navy
Pope, Glenn A.		——
Prescott, Walton		Army
Quigley, John Scott		Navy
Rahn, Paul Clinton		Navy
Redfield, Robert Lowell		——
Reis, Joseph B.		——
Reynolds, Theodore Eric		Navy
Rice, Arthur H.		Army
Richards, Charles Erskine		Navy
Robertson, John W.		——
Robinson, Hewitt H.	Lt. Col.	Army
Roe, Harold E.	Major	Army
Ryan, Paul H.		Navy
Samson, Paul C.	Captain	Army
Sbarbaro, Victor E.		Navy
Scott, Benton V.		Navy
Sharpsteen, Jay R.		Navy
Sheafe, Earle	Lt. Col.	Army
Skilling, Leonard E.		——
Smith, Callendar		——
Smith, Chester R.	Major	Army
Smith, Sydney K.		——
Stark, James	Captain	Army
Steinmetz, Arthur F.		Navy
Steinmetz, John R.		Navy
Stephens, Bruce Miller		——
Stephens, Stuart Barclay		——
Stevenson, Charles C.		——
Stratton, James M.		——
Struble, Homer Pearson		——
Tattersall, Kenneth L.	Lt. Comdr.	Navy
Taylor, Edwin M.		Navy
Taylor, Leland Harris	Lt. Comdr.	Navy
Thebault, William Maxwell		——
Thompson, Arthur R.		——
Thompson, Kenneth J.	Major	Army
Toffelmier, Douglas D.	Lt. Comdr.	Navy
Tucker, Marshall B.		Army
Twiss, Arthur R.		Army
Van de Carr, Francis R.		Army
Walker, Ralph S.		——
Westphal, Edward A.		——
Whiting, Edward G.		Army
Wiesinger, Warren E.		Navy
Yee, Jacob J.		——
Young, Richard A.		Army

II

Butte-Glenn County Medical Society

Members of the Butte-Glenn County Medical Society on active duty with the Army and Navy.

(Report as of September 29, 1943. Total Number, 9.)

Benninger, Charles H., Jr.	Captain	Army
Carey, Willard W.	Captain	Army
Fabian, John P.	Lt. Comdr.	Navy
Frost, Garrison Albert	Captain	Army
Guernsey, C. Meredith	Captain	Army
Hepplewhite, J. G.	Captain	Army
Olker, Louis C.	Captain	Army
Perry, William James	Captain	Army
White, John Huffman	Major	Army

III

Contra Costa County Medical Society

Members of the Contra Costa County Medical Society on active duty with the Army and Navy.

(Report as of November 8, 1943. Total Number, 6.)

Coates, Gaines L.	Navy
Dietderich, C. E.	Navy

Name	*Rank* (if known)	*Service* (if known)
Fitzgerald, J. J.		Army
Flanders, H. B.		——
Gerow, Elwyn C.		Navy
Winn, Paul F.		——

IV

Fresno County Medical Society

Members of the Fresno County Medical Society on active duty with the Army and Navy.

(Report as of November 1, 1943. Total Number, 38.)

Adams, William L., Jr.		Army
Arthur, James Melvin	Lieut.	Navy
Awtrey, Hugh		Navy
Badertscher, Victor A.		Navy
Blecker, R. F.		Army
Bolkovatz, J. F.		Army
Cabell, C. L.		Navy
Dau, Neil J.		Navy
Doane, Clarmont P.		Navy
Downing, F. Harold	Lt. Comdr.	Navy
Ellefson, O. D.		Navy
Falk, Sidney		Army
Gaede, Menno S.		Army
Ghormley, Verne Gordon		Army
Gilliland, F. I.		Army
Holmes, Kendall B.		Army
Hopkins, Thorne		Army
Humphreys, J. M.		Navy
Jacobson, H. A.		Navy
James, Lloyd B.		Army
Jeans, Virgil E.		Army
Jing, Fred Q.		Army
Kellogg, Pearson		Navy
Klein, Thomas	1st Lieut.	Army
McGehee, W. H.		Army
Mitchell, Charles Sutherland		Army
Morgan, John D.		Army
Murray, John Francis	Lieut.	Army
Overpeck, Darrell	Captain	Army
Pendergrass, C. I.	Lieut.	Navy
Riley, William H.		Army
Ross, Samuel		Army
Scott, Raymond		Navy
Sharp, Lenner F.		Army
Smith, Joseph R.	Captain	Army
Solberg, Lawrence A.	Lieut.	Army
Sorauf, Bernard M.		Navy
Studebaker, Leland F.		Army

V

Humboldt County Medical Society

Members of the Humboldt County Medical Society on active duty with the Army and Navy.

(Report as of September 29, 1943. Total Number, 9.)

Brown, Joseph M.	Captain	Army
Chain, John S.	Major	Army
Falk, Charles C., Jr.	Major	Army
Goodman, Max	Major	Army
Hoilien, Maurice	Captain	Army
Kramer, Lowell G.	Lt. Comdr.	Navy
Myers, Orris R.	Comdr.	Navy
Olsen, Fred	Captain	Army
Todd, Max Alexander	1st Lieut.	Army

VI

Imperial County Medical Society

Members of the Imperial County Medical Society on active duty with the Army and Navy.

(Report as of October 1, 1943. Total Number, 9.)

Name	*Rank* (if known)	*Service* (if known)
Canfield, Merritt C.	Captain	Army
Clarke, William A.	Captain	Army
Cutshaw, Charles M.	Lieut. (s. g.)	Navy
Davidson, Benjamin R.	Captain	Army
Gregg, Harold J.	Lt. Comdr.	Navy
Holleran, George C.	Captain	Army
Mitchell, Edward	Lieut. (s. g.)	Navy
Powers-Heald, Fredrick	Captain	Army
Zinke, Ernest A.	Lieut. (s. g.)	Navy

VII

Inyo-Mono County Medical Society

Members of the Inyo-Mono County Medical Society on active duty with the Army and Navy.

(Report as of October 28, 1943. Total Number, 4.)

Dueker, Howard W.	Lieut. (j. g.)	Navy
Russell, William McKinley	Comdr.	Navy
Schatz, Walter R.	Captain	Army
Scott, Clarence L.	Captain	Army

VIII

Kern County Medical Society

Members of the Kern County Medical Society on active duty with the Army and Navy.

(Report as of October 12, 1943. Total Number, 19.)

Abbott Dee L.	Lt. Comdr.	Navy
Baisinger, Leo F.	Captain	Army
Bell, Hugh W.	Lieut.	Army
Bishop, Harry	Lieut.	Navy
Cawley, John J.	Major	Army
Colby, Eric F.	Captain	Army
Douds, Robert	Lieut.	Army
Garner, George W.	Captain	Army
Gundry, Francis	Lieut.	Navy
Johnson, J. Dykes	Lieut.	Navy
McDonald, Frank	Major	Army
McEwen, William L.	Captain	Army
McNamara, Thadeus	Lieut.	Navy
Moore, Carl L.	Captain	Army
Ogden, Roderick A.	Captain	Army
Stanton, James	Captain	Army
Walthall, Felix E.	Lieut.	Navy
Ware, James	Comdr.	Navy
Wood, Rodney	Lieut.	Army

IX

Kings County Medical Society

Members of the Kings County Medical Society on active duty with the Army and Navy.

(Report as of September 28, 1943. Total Number, 8.)

Chamlee, William F.	Lt. Comdr.	Navy
Hagen, Earl O.	Lieut.	Army
Levin, Walter N.	Lieut.	Army
Messenger, Thomas T.	Lieut.	Army
Murphy, Paul L.	Captain	Army
Rosson, Charles T., Jr.	Major	Army
Stamler, Allan E.	Major	Army
Young, John Paul	Lieut.	Army

X

Lassen-Plumas-Modoc County Medical Society

Members of the Lassen-Plumas-Modoc County Medical Society on active duty with the Army and Navy.

(Report as of October 11, 1943. Total Number, 5.)

Coulter, John D.		Army
Holm, Bernard S.	Lt. Comdr.	Navy
Levin, Herman G.		Army
McKenney, Phillip W.		Navy
Moore, John W.		Army

XI

Los Angeles County Medical Association

Members of the Los Angeles County Medical Association on active duty with the Army and Navy.

(Report as of December 6, 1943. Total Number, 751.)

Name	*Rank* (if known)	*Service* (if known)
Abbott, Charles Grant	1st Lieut.	Army
Alexander, Harry H.	Captain	Army
Allen, Carlton S.	Lt. Col.	Army
Allen, Ralph Warren	Lt. Comdr.	Navy
Alsberge, Edward Wallar	Captain	Army
Alsberge, Marden	Captain	Army
Althouse, Hugh C.	1st Lieut.	Army
Alward, H. Cedric	Major	Army
Andersen, George Carl	Lieut. (j. g.)	Navy
Anderson, Floyd K.	Major	Army
Anderson, Forrest N.	Major	Army
Anderson, Frank M.	1st Lieut.	Army
Anderson, Herbert, Jr.	Lt. Comdr.	Navy
Anderson, Milford X.	Major	Army
Anderson, Stanley Barton	Lt. Col.	Army
Andrews, Herbert Jerome	Lt. Comdr.	Navy
Anton, Albert	Captain	Army
Arkush, Albert S.	Lt. Comdr.	Navy
Arnold, Ferris L.	Major	Army
Arnold, Walter F.	Lieut.	Navy
Auerbach, Oscar	Major	Army
Babcock, Donald Tisdale	Major	Army
Bachrach, William Harris	1st Lieut.	Army
Baldwin, L. Grant	Major	Army
Ball, Franklin I.	Major	Army
Balyeat, Frederick S.	Lt. Comdr.	Navy
Barmore, Merrill Gorr	Lt. Comdr.	Navy
Barnes, Norman J.	Lieut.	Army
Barnum, Glenn L.		Navy
Barshop, Nathan	Captain	Army
Barton, Edward Williams, Jr.	Lt. Comdr.	Navy
Beckerman, George E.	1st Lieut.	Army
Bedri, Marcel	Captain	Army
Beerman, Herman M.	Major	Army
Behrendt, R. A.	Lieut.	Navy
Behrens, Herbert C.	Lieut.	Army
Benadom, Samuel Coy	Lieut.	Army
Benbrook, Samuel Parker	Lieut.	Navy
Bennett, Edwin S.	Lt. Col.	Army
Bennett, J. Tracy	Private	Army
Bennett, Louis C.	Major	Army
Bennetts, Frederick A.	Major	Army
Bergman, George Clyde	Major	Army
Berne, Clarence John	Major	Army
Bernstein, Theodore I.	Captain	Army
Billig, Harvey Ellsworth, Jr.	Lieut.	Navy
Bishop, Edwin T.	1st Lieut.	Army
Blackmun, Robert Lynwood	Lieut.	Army
Blatherwick, Norman	Lieut.	Army
Blood, Russell Henry	Lt. Comdr.	Navy
Blotky, Myron J.	Captain	Army
Bodner, Henry	1st Lieut.	Army
Bogen, Emil	Lt. Comdr.	Navy
Boland, Edward W.	Captain	Army
Bower, Albert G.	Comdr.	Navy
Boyes, Joseph H.	Major	Army
Bradford, Fred E.	Lt. Comdr.	Navy
Branch, C. H. H.	Lieut.	Army
Bravo, Francisco	Captain	Army
Breitman, H. B.	Captain	Army
Brem, Thomas H.	Captain	Army
Brewer, Lyman A.	Captain	Army
Briesen, Hans V.	Comdr.	Navy
Briggs, Wilford Myron	Lt. Comdr.	Navy
Brown, George D.	Captain	Army
Brown, George E.	1st Lieut.	Army
Brown, Walter B.	Major	Army
Brownfield, Bernard	Captain	Army
Brownsberger, Sidney	Captain	Army
Bruechert, S. S.	Captain	Army
Bruson, Solomon	Captain	Army
Bryant, Ben L.	Lt. Comdr.	Navy
Buck, Leonard S.	1st Lieut.	Army
Budd, John W.	Lt. Comdr.	Navy
Budge, Edwin Stratford, Jr.	Lieut. (s. g.)	Navy
Bullis, John A.	Lieut. (s. g.)	Navy
Bullock, Lewis T.	Captain	Army
Burger, Raymond A.	Captain	Army
Burke, George T.	Lieut.	Navy
Burns, George Creswell	Major	Army
Burns, Herschel S.	Major	Army
Burns, Melton B.	Captain	Army
Burston, Herschel H.	1st Lieut. (inactive)	Army
Butler, Oliver W.	Comdr.	Navy
Byrne, Ralph Vincent	Lt. Comdr.	Navy
Cameron, Markley C.	Lt. Comdr.	Navy
Cameron, V. L.	Lt. Comdr.	Navy
Campbell, Clayton C., Jr.	Major	Army
Campbell, George Malcolm	1st Lieut.	Army
Campbell, Henry S.	Major	Army
Campbell, Roy	Captain	Army
Cantarow, J. Harold	Captain	Army
Carter, Martin G.	Lt. Comdr.	Navy
Carter, Robert V.	Lieut.	Army
Caruso, Tenero Danny	Lieut.	Navy
Casper, P. Conrad	1st Lieut.	Army
Castanares, S.	Major	Army
Castlen, Charles R.	Lt. Col.	Army
Cates, Horace B.	Captain	Army
Chapman, Edwin S.	Captain	Army
Chapman, James L.	Lt. Comdr.	Navy
Chapman, Ralph	1st Lieut.	Army
Chier, Reuben D.	1st Lieut.	Army
Chock, Chong Auck	1st Lieut.	Army
Churchill, Ambrose S.	Captain	Army
Clegg, John Gibson	1st Lieut.	Army
Cloninger, Ralph C.	1st Lieut.	Army
Coggin, Charles B.	Major	Army
Cohn, Harold A.	Captain	Army
Cole, Cecil C.	Captain	Army
Collins, Don C.	Lt. Col.	Army
Comstock, Delos	Captain	Army
Cook, Wells C.	Captain	Army
Cooper, Z. P.	Captain	Army
Corlette, Marvin B.	Captain	Army
Cornell, Chester E.	Captain	Army
Cosgrove, Claire Peter	Lt. Comdr.	Navy
Cosgrove, Jay Baker	Captain	Army
Costolow, William Evert	Captain	Navy
Covell, Harold D.	1st Lieut.	Army
Cozen, Lewis N.	Major	Army
Crane, Edward Harrison, Jr.	Lieut.	Navy
Crane, Norman F.	Captain	Army
Crockett, Herbert G.	Captain	Army
Crozier, Henry C.	Captain	Army
Crum, John David	Lieut. (j. g.)	Navy
Cummings, Harold	Lieut.	Navy
Curtin, Edward D.	Lieut. (j. g.)	Navy
Curtis, Don McCauley	1st Lieut.	Army
Dahl, Clarence Arnold	Lt. Comdr.	Navy
Daniells, Arthur G., Jr.	Lt. Comdr.	Navy
Daniels, E. H.	Lt. Comdr.	Navy
Darby, John Sangster	Captain	Army
Darnell, Clarence A.	Lt. Col.	Army
Dassett, Joseph W.	Lt. Comdr.	Navy
Davis, John D.	Lt. Col.	Army

Name	Rank (if known)	Service (if known)
Davis, William D.		Army
Davison, Claude L.	Lt. Comdr.	Navy
Deakers, R. P.	1st Lieut.	Army
Dean, James Reeve	Lt. Col.	Army
DeLong, Everett W.	1st Lieut.	Army
Delphey, William Edward	Lt. Comdr.	Navy
Demaree, E. W.	Major	Army
Devin, Stephen B.	Captain	Army
Dickey, Clarence Dudley, Jr.	Lt. Comdr.	Navy
Dickmann, Richard C.	Captain	Army
Dixon, Chester Darwin	Lt. Comdr.	Navy
Dixon, Clarence E.	Captain	Army
Dixon, Henry Lloyd	Lt. Comdr.	Navy
Dodd, A. M.	Major	Army
Dodge, Douglas Rude	Lieut.	Army
Donohoe, E. C.	Major	Army
Doroshow, George D.	Captain	Army
Douglass, George Hall	Captain	Army
Downey, Thomas P.	1st Lieut.	Army
Drane, Walter Hugh, Jr.	Captain	Army
Dressel, Paul Arthur	1st Lieut.	Army
Duffy, J. James	Captain	Army
Dugan, Roger J.	1st Lieut.	Army
Dunbar, William V.	Lt. Comdr.	Navy
Duncan, John J.	Captain	Army
Durkin, John Joseph	Lt. Comdr.	Navy
Earwood, E. R.	Major	Army
Easley, Clifford Earl	Lieut.	Navy
Ebers, Theodore M.	Lieut.	Navy
Eckhardt, Wymond	Captain	Army
Einhorn, Benjamin	Lieut. (s. g.)	Navy
Eldredge, H. S.	Lieut. (s. g.)	Navy
Eldredge, R. Bruce	Captain	Army
Elerding, George William	Lieut. (j. g.)	Navy
Elgin, James Carroll	1st Lieut.	Army
Ellik, Milo	Lieut. (s. g.)	Navy
Ellis, Orwyn Haywood	Lieut. (j. g.)	Navy
Elsbach, Kurt J.	Captain	Army
Emerson, Charles Van Arsdale	Lieut. (s. g.)	Navy
Eng, Samuel Yen	1st Lieut.	Army
Engelberg, Hyman	1st Lieut.	Army
English, Glenn G.	Lt. Comdr.	Navy
Epstein, Herman C.	1st Lieut.	Army
Evans, Leland M.	Captain	Army
Evans, Richard D.	Major	Army
Ewing, John Paul	Lieut.	Navy
Fagan, Shuler Francis	Major	Army
Faier, Herman I.	Major	Army
Falconer, F. H.	Lt. Comdr.	Navy
Farrier, Robert A.	Lieut. (s. g.)	Navy
Feder, Bernard H.	Lieut.	Army
Feder, Morris R.	1st Lieut.	Army
Feingold, Benjamin F.	Lt. Comdr.	Navy
Fernald, John M.	Captain	Army
Fields, H. Maxwell	Captain	Army
Fine, Irwin Abraham	Captain	Army
Fink, Morris L.	1st Lieut.	Army
Finocchairo, C.	Captain	Army
Fish, Lester Warren	Lt. Col.	Army
Fisher, Gaylord Lee	Lieut. (s. g.)	Navy
Fisher, Robbin E.	Lt. Comdr.	Navy
Fitzgerald, Charles E.	Lt. Comdr.	Navy
Flyer, Harry	1st Lieut.	Army
Fogel, Edward Theodore	1st Lieut. (inactive)	Army
Foley, Maurice P.	Captain	Army
Folkenberg, Alvin W.	Lt. Comdr.	Navy
Folsom, Clarence Hugo	Lt. Comdr.	Navy
Frazier, Frank F.	1st Lieut.	Army
Frick, William Oliver	Lieut. (j. g.)	Navy
Friedman, Lawrence J.	Captain	Army
Gafford, James A., Jr.	Lieut.	Navy
Gallup, Charles A.	Lieut.	Army
Gardiner, Joseph P.	Captain	Army
Garrett, Garland F.	Lieut. (s. g.)	Navy
Garrison, W. P.	Lt. Comdr.	Navy
Gasteiger, Ernest S.	Lt. Comdr.	Navy
Gay, Michel	Captain	Army
Gazzaniga, D. A.	Lieut.	Navy
Gendel, Samuel	Major	Army
Gernand, Henry Chris	Lt. Comdr.	Navy
Gewertz, Louis L.	Captain	Army
Gibboney, Don B.	Captain	Army
Gibson, William R.	Captain	Army
Gifford, John Harry	Lieut. (j. g.)	Navy
Gilbert, Elmer W.	Major	Army
Gilliland, Roy C.	Captain	Army
Globerson, Irwin	1st Lieut.	Army
Gobbell, Willard M.	Lieut. (s. g.)	Navy
Godard, Clarence H.	Major	Army
Godett, M. R.	Captain	Army
Gogol, Louis J.	Captain	Army
Goldberg, Percy H.	Major	Army
Goldenberg, Julius L.	Captain	Army
Golenternek, Dan	Captain	Army
Goodcell, Ross A.	Lt. Comdr.	Navy
Gooel, Elmer F.	Captain	Army
Gordon, Gerald	1st Lieut.	Army
Gordon, Kenneth W.	Captain	Army
Gould, Arthur	Captain	Army
Grant, Ben E.	Colonel	Army
Grant, Leslie C.	Lieut.	Navy
Grant, R. S.	Captain	Army
Graves, Charles Allen	Lt. Comdr.	Navy
Greene, H. Harvey	Lieut. (s. g.)	Navy
Greenson, Ralph R.	1st Lieut.	Army
Griffith, Powell West	Lieut. (s. g.)	Navy
Griffith, William Hugh	Captain	Army
Grishaw, William H.	Captain	Army
Groat, M. J.	1st Lieut.	Army
Groskloss, H. H.	Lt. Comdr.	Navy
Guinney, Francis E.	1st Lieut.	Army
Gunther, Lewis	Lt. Comdr.	Navy
Gurdin, Michael M.	Lieut.	Navy
Hadley, R. C.	1st Lieut.	Army
Hall, Colby	Captain	Army
Hall, George E.	Captain	Army
Hallstone, Victor E.	Lieut. (j. g.)	Navy
Hamilton, Van Rensslaer	Captain	Army
Hanna, Ralph	1st Lieut.	Army
Harmon, George A.	Lieut.	Army
Harner, C. E.	Comdr.	Navy
Harper, Howard E.	Captain	Army
Harris, Joseph M.	Major	Army
Harris, Marvin S.	Captain	Army
Harris, Thomas L.	Lieut.	Navy
Harrison, R. Stewart	Captain	Army
Haskell, Joe Spangler	Major	Army
Hatfield, Howard L.	Captain	Army
Hauck, Richard F.	Lieut.	Navy
Hauser, Vernon F.	Captain	Army
Hawley, Carl J.	Major	Army
Heath, Richard S.	1st Lieut.	Army
Heckel, Donald Q.	1st Lieut.	Army
Henderson, Jesse L.	Comdr.	Navy
Hendricks, Coleman B.	Captain	Army
Henrichsen, Arthur L.	Captain (inactive)	——
Henriksen, Erle	Major	Army
Henry, Merlyn George	Lt. Comdr.	Navy
Henstell, Henry H.	1st Lieut.	Army
Hermes, Marvin J.	Lieut.	Army
Herscher, Herbert L.	Lt. Comdr.	Navy
Hersh, Julius	1st Lieut.	Army
Hershberger, Lloyd R.	Lieut.	Navy
Hertzog, Francis C.	Lt. Comdr.	Navy

Name	Rank (if known)	Service (if known)
Hiatt, Nathan	Captain	Army
Hickey, N. Glenn	Captain	Army
Hillyer, Ernest C.	Comdr.	Navy
Hilty, Henry L.	1st Lieut.	Army
Hittelman, Joseph	1st Lieut.	Army
Hodgdon, Frank W.	Major	Army
Hogue, William J.	Captain	Army
Holden, Harold M.	Major	Army
Hollands, R. A.	Captain	Army
Hollombe, Benjamin S.	1st Lieut.	Army
Holt, C. Zeno	Colonel	Army
Homme, O. H.	Major	Army
Hoover, Bryan R.	Captain	Army
Hope, Robert B.	Captain	Army
Hosmer, Fell	Lieut.	Army
Houck, George H.	Major	Army
Hromadka, John B.	Lieut. (s. g.)	Navy
Huff, Louis L.	Captain	Army
Hughes, Ronald L.	Lieut.	Army
Hughes, S. E., Jr.	Comdr.	Navy
Humphreys, Patrick C.	Captain	Army
Hunnicutt, Cecil C.	Captain	Army
Hunnicutt, Leland G.	Major	Army
Hunt, Frederick T.	Lieut.	Navy
Hurd, Arthur Henry	Lieut. (inactive)	Navy
Hyman, Earl	Lt. Comdr.	Navy
Ilfeld, Frederick W.	Major	Army
Imerman, Carlyle P.	Captain	Army
Imler, Harper G.	Major	Army
Irish, Cullen Ward	Lt. Col.	Army
Irvine, Rodman	Captain	Army
Irvine, Wendell C.	Captain	Army
Jackson, John L.	Lt. Comdr.	Navy
Jacob, Harry H.	Major	Army
Jacobs, Melville	Major	Army
Jacobus, Willis L., Jr.	Major	Army
James, Carvel M.	Lt. Comdr.	Navy
James, John Basil	Captain	Army
Jamison, H. W.	Captain	Army
Jenney, E. Ross	Major	Army
Johnson, Clarence Emory	Captain	Army
Johnson, Donovan	Lt. Comdr.	Navy
Johnson, Franklyn H.	Lieut. (s. g.)	Navy
Johnson, Harvey	Major	Army
Johnson, James B.	Captain	Army
Johnson, Robert Walton	Lt. Comdr.	Navy
Johnson, William T.	Captain	Army
Jones, Archie A.		Navy
Jones, Floyd H.	Captain	Army
Jones, George W.	Lt. Comdr.	Navy
Jones, Glen Ellis	Captain	Army
Jones, Milton Randle	Lieut.	Navy
Josephs, Irving L.	Lt. Comdr.	Navy
Josephs, Louis	Comdr.	Navy
Judge, W. Donald	Major	Army
Kaftan, Ludwig L.	Lt. Comdr.	Navy
Kahler, James E.	Captain	Army
Kaplan, Harry E.	Lt. Comdr.	Navy
Kay, Raymond	Captain	Army
Kayland, Stuart	1st Lieut.	Army
Keipp, James V.	1st Lieut.	Army
Keller, Thomas Brewster	Captain	Army
Kellogg, Frederick	Lt. Col.	Army
Kelso, Raymond W.	Major	Army
Keltz, Charles	1st Lieut.	Army
Kennedy, Robert A.	1st Lieut.	Army
Kerber, Harry E.	Captain	Army
Kesling, Emmett	Captain	Army
Keye, John D.	Lt. Comdr.	Navy
Kibby, S. V.	Lt. Col.	Army
Kiefer, Albert L.	Captain	Army
Kimball, Theodore Spalding	Major	Army
King, Jack Winfield	Lieut.	Army
King, Robert W.	Captain	Army
King, Stuart D.	Captain	Army
Kinyoun, Floyd H.	Major	Army
Kinzer, E. Earll	Lieut.	Army
Kirby, Harry W. B.	Lieut.	Navy
Kirchner, Arthur A.	Captain	Army
Kirchner, Herbert J.	Captain	Army
Kiskadden, William S.	Major	Army
Klausner, John T.	Major	Army
Klor, Samuel J.	Captain	Army
Knoll, Marvin D.	Captain	Army
Knott, Norman Laverne	Lieut.	Army
Knox, Stuart C.	Lieut. (s. g.)	Navy
Kobal, Arthur L.	1st Lieut.	Army
Kremers, Marshall	1st Lieut.	Army
Krieger, Herbert D.	Captain	Army
Krieger, Sherburne	Major	Army
Krohn, Harry N.	1st Lieut.	Army
Krohn, Leon	Captain	Army
Lacoe, Jeremiah R.	Captain	Army
Lamont, Herbert A.	Lt. Comdr.	Navy
LaMont, Wyant	Lt. Comdr.	Navy
Landers, Clyde H.	Captain	Army
Langley, Robert William	Lt. Comdr.	Navy
Larson, E. Eric	Comdr.	Navy
Laubersheimer, Anton	Captain	Army
Lauer, Calvin A.	Lt. Comdr.	Navy
Leake, William H.	Lt. Comdr.	Navy
Leavitt, Arthur S.	Major	Army
Leffingwell, F. E.	Major	Army
Levan, Paul	1st Lieut.	Army
Levin, Edward	1st Lieut.	Army
Lewis, Charles H.	Captain	Army
Linne, Francis B.	Major	Army
Little, Paul Francis	Lieut.	Navy
Lloyd, Oliver Dale	Captain	Army
Lobel, Charles S.	Lieut.	——
Lomas, Jack B.	Captain	Army
Lomas, Max I.	Captain	Army
Lopez, Charles J. J.		Army
Loughlin, Edward L.	Lt. Comdr.	Navy
Lovell, R. A.	Major	Army
Lowry, M. Lester	Captain	Army
Loy, Monroe F.	Captain	Army
Luck, James V.	Captain	Army
Ludwig, J. Lafe	Lieut. (s. g.)	Navy
Lund, Grant	Captain	Army
Lund, LeVal	Lt. Comdr.	Navy
Lynch, James M.	Lt. Comdr.	Navy
Lynn, William F.	Lieut. (s. g.)	Navy
Lyster, Russell W.	Captain	Army
Macauley, James Henry	Lt. Comdr.	Navy
Mack, Edward G.	Captain	Army
Macpherson, William A.	Captain	Army
Maeth, Joseph Leo	Captain	Army
Malis, Sol	Major	Army
Manchester, Raymond Day	Lieut.	Army
Mandel, Charles	Captain	Army
Maner, George Darby	Lt. Comdr.	Navy
Manning, John G.	Lt. Col.	Army
Mantle, Verne Miles	Lt. Comdr.	Navy
Mapes, Russell W.	Major	Army
Marco, Joseph		Army
Marcus, Simson	1st Lieut.	Army
Marians, Abraham	Captain	Army
Mariette, E. L.	Captain	Army
Marks, Joseph Herbert	Captain	Army
Marks, Max	Captain	Army
Marshall, James Max	Lt. Comdr.	Navy
Mason, Verne R.	Lt. Col.	Army
Massell, Theodore B.	Captain	Army

Name	*Rank* (if known)	*Service* (if known)
Mather, Ralph W.	Lieut. (s. g.)	Navy
Matzen, Warren C.	Captain	Army
Mayer, Harry J.	Captain	Army
Mayers, Morton M.	Lieut.	Navy
McCloy, Neil P.	Lieut.	Army
McClurkin, Arthur A.	Major	Army
McCune, Scott S.	Major	Army
McCuskey, Charles F.	Major	Army
McDermott, John C.	Lieut. (s. g.)	Navy
McDonald, John Bowen	1st Lieut.	Army
McElhinney, Philip P. B.	Comdr.	Navy
McEvers, Albert E.	Colonel	Army
McGowan, Donald O.	Major	Army
McGranahan, James	Lt. Comdr.	Navy
McKeever, Francis M.	Lt. Col.	Army
McKenna, Stephen E.	Major	Army
McKibbin, John	Captain	Army
McKinnon, Douglas D.	Lt. Comdr.	Navy
McMaster, Paul E.	Lt. Comdr.	Navy
McMillen, Charles H., Jr.	Lieut. (s. g.)	Coast Guard
McNeil, Robert Jenks	1st Lieut.	Army
McPherson, Henry Arthur	1st Lieut.	Army
McReynolds, R. T.	Lieut.	Navy
Meals, R. W.	Major	Army
Mendelsohn, Howard A.	1st Lieut.	Army
Mendenhall, Arthur J.	Lieut. (s. g.)	Navy
Merchant, Edward B., Jr.	Lieut. (j. g.)	Navy
Mershon, Harry Franklin	Lieut.	Navy
Miller, Alden H.	Lieut.	Navy
Miller, C. Duane	Lt. Comdr.	Navy
Miller, David	1st Lieut.	Army
Mintz, I. Lew	1st Lieut.	Army
Mitchell, Cyril Louis	1st Lieut.	Army
Mitchell, William J.	Major	Army
Mitchelson, Delmar S.	Captain	Army
Molony, Clement J.	Captain	Army
Molony, William R., Jr.	Lt. Comdr.	Navy
Mooney, Herbert S.	Major	Army
Moore, Oliver M.	Major	Army
Moore, Robert L.	Major	Army
Moran, Frank A.	Captain	Army
Morgan, Wendell A.	Captain	Army
Mortensen, William L.	Captain	Army
Motchan, Louis A.	1st Lieut.	Army
Mourer, Lyle A.	Major	Army
Mozar, Harold	Captain	Army
Mullen, Robert McGee	1st Lieut.	Army
Mulligan, Harold R.	Comdr.	Navy
Murphy, John Aloysius	1st Lieut.	Army
Murray, Saunders	Captain	Army
Muskin, Nathan	Major	Army
Nador, George	Captain	Army
Nasatir, A. Victor	Captain	Army
Nebeker, Don Paul	Lieut.	Navy
Nees, Oliver Roscoe	Comdr.	Navy
Nemethi, Carl Edward	1st Lieut.	Army
Nesburn, Henry R.	Lt. Comdr.	Navy
Netzley, Ralph E.	Captain	Army
Neufeld, Alonzo J.	Major	Army
Newbarr, Frederick D.	Lt. Comdr.	Navy
Newkirk, Merlin L.	Captain	Army
Newman, Ben A.	Major	Army
Newman, Irving G.	1st Lieut.	Army
Nichols, Jack	Captain	Army
Nichols, James E., Jr.	Captain	Army
Niebergall, Herbert Arthur	Lt. Comdr.	Navy
Nisbet, Thomas W.	Major	Army
Nixon, Norman	Major	Army
Noble, Thomas Elwood	Lt. Comdr.	Navy
Norman, Sylvester P.		Navy
Norwood, Jackson	Lieut. (j. g.)	Navy
O'Connor, Joseph P.	Lt. Comdr.	Navy
Olney, Millard P.	Lieut.	Army
Olsen, Alonzo Young	1st Lieut.	Army
O'Neill, James Norman	Lt. Comdr.	Navy
O'Neill, Thomas Joseph	Lt. Comdr.	Navy
Orleans, Leslie S.	1st Lieut.	Army
Ostrander, Harold R.	Captain	Army
Oyler, J. Dickson	Lt. Comdr.	Navy
Page, Emery Phillips	Lieut. (j. g.)	Navy
Pahl, Blythe W.	Lt. Comdr.	Navy
Paine, Norman Carr	Lt. Comdr.	Navy
Pallette, Edward C.	Major	Army
Parks, Floyd R.	Major	Army
Parks, Ross Vernon	Lieut.	Navy
Pattison, Arthur C.	Major	Army
Paul, Olin	Captain	Army
Payne, Royal C.	Major	Army
Pelia, Lewis J.	1st Lieut.	Army
Pendleton, Waldo Cooper	Captain	Army
Pendleton, Walter R.	Captain	Army
Pentz, Clarence Rolland	Lt. Comdr.	Navy
Perlmutter, Louis Judea	1st Lieut.	Army
Perrie, Samuel	Lieut.	Army
Person, Edward C.	Lt. Comdr.	Navy
Peterson, M. H. A.	Captain	Army
Pettet, Charles Hensley	1st Lieut.	Army
Phillips, Louis	Lieut. (inactive)	Navy
Pierce, Wilmot Frank	Lt. Comdr.	Navy
Pierose, Perry N.	1st Lieut.	Army
Pillsbury, Stirling	Major	Army
Pitlick, William J.	1st Lieut.	Army
Pobirs, Frederick W.	1st Lieut.	Army
Pohlman, David A.	Captain	Army
Pohlman, Max E.	Lieut. (j. g.)	Navy
Popkin, Roy J.	Major	Army
Posner, Charles	Captain	Army
Potasz, Thomas M.	Lt. Col.	Army
Powers, Edward S.	Captain	Army
Presnell, James F.	Major	Army
Pressman, Joel Jay	Lt. Comdr.	Navy
Prigge, Edward K.	Lt. Col.	Army
Priver, Maurice S.	Captain	Army
Quinn, Joseph V.	Captain	Army
Rambo, William H.	Lt. Comdr.	Navy
Raney, Aidan A.	Major	Army
Ray, Earl B.	Lt. Col.	Army
Re Bell, Frederick G.	Captain	Army
Redfern, Wendell M.	Captain	Army
Redpath, N. J.	1st Lieut.	Army
Reeder, Charles W.	Comdr.	Navy
Reeves, David Lander	Lt. Col.	Army
Regan, James F.	Lieut.	Navy
Regan, Maurice J.	1st Lieut.	Army
Reider, Norman	Captain	Army
Reinard, Erich	Captain	Army
Reinertsen, B. R.	Comdr.	Navy
Rey, Delbert F.	1st Lieut.	Army
Reynolds, Frederick G.	Captain	Army
Rhind, Ralph	Lieut. (s. g.)	Navy
Richardson, Gordon Lewis	Captain	Army
Richardson, William A.	Major	Army
Riddell, Herman I.	1st Lieut.	Army
Riskind, Lester A.	Lieut. (s. g.)	Navy
Rivera, Gabriel Alfonso	Captain	Army
Roath, Clinton A.	1st Lieut.	Army
Roberts, Gilbert J.	Lt. Comdr.	Navy
Roberts, John F.	Lt. Col.	Army
Roehm, E. A.	Major	Army
Roen, Paul B.	Lt. Comdr.	Navy
Rogers, Layton	1st Lieut.	Army
Rogers, Maurice B.	Captain	Army
Rogers, Thomas J.	1st Lieut.	Army
Rogers, Wilbur G.	Lieut. (s. g.)	Navy

Name	*Rank* (if known)	*Service* (if known)
Rombeau, Lee P.	Lieut.	Army
Rose, Sidney J.	Captain	Army
Rosenberg, I. G.	Lieut. (j. g.)	Navy
Rosenberg, Maurice W.	Captain	Army
Rosenvold, Lloyd Kenneth	Captain	Army
Rosoff, Leonard	Captain	Army
Rosove, Leon	Lt. Comdr.	Navy
Ross, Rex L.	Lieut. (s. g.)	Navy
Rosser, Bernard Howard	Captain	Army
Rothman, Philip Elias	Lt. Comdr.	Navy
Rover, Henry Paul	Lt. Comdr.	Navy
Rubenstein, Victor G.	Major	Army
Rubin, Henry Joel	1st Lieut.	Army
Ruddock, John Carroll	Captain	Navy
Rumack, Abe	1st Lieut.	Army
Ryan, Clark D.	Lt. Comdr.	Navy
Rydholm, Carl Oliver	Captain	Army
Sacasa, Carlos F.	Major	Army
St. Geme, J. W.	Lt. Comdr.	Navy
Salomon, Werner	Captain	Army
Sands, Robert L.	Lt. Col.	Army
Saverien, Arnold E.	Comdr.	Navy
Saxon, Albert	Captain	Army
Schade, Frank F.	Lt. Col.	Army
Scheffel, Alfred Garland	Lieut. (j. g.)	Navy
Schenk, Harry Leon	Major	Army
Schield, Emmett LeRoy	Major	Army
Schiffler, Robert Joseph	Lieut. (j. g.)	Navy
Schlumberger, Frederick C.	Lieut. (s. g.)	Navy
Schmidt, Allen R.	Captain	Army
Schmidt, Philipp E.	Major	Army
Schmoele, John M.	Captain	Navy
Schneider, Maurice	1st Lieut.	Army
Scholtz, Julius R.	Major	Army
Schroeder, Ralph L.	Captain	Army
Schube, Purcell George	Lt. Comdr.	Navy
Schwartz, J. L.	Captain	Navy
Schwartz, Walter F.	Captain	Army
Scobee, J. Edwin	Lt. Comdr.	Navy
Scofield, Dean S., Jr.	Lieut. (j. g.)	Navy
Scoins, William H.	Lt. Comdr.	Navy
Seapy, Lewis F.	Captain	Army
Seitter, Paul F.	Lieut. (j. g.)	Navy
Seletz, Emil	Captain	Army
Semenov, Herman Z.	Major	Army
Shachtman, Joseph M.	Major	Army
Shackford, Bartlett C.	Comdr.	Navy
Shaw, Gerald William	Lt. Comdr.	Navy
Shear, Sidney P.	Captain	Army
Sheffner, Sidney A.	Captain	Army
Shelby, Donald C.	Lt. Comdr.	Navy
Shelden, Charles H.	Lieut. (s. g.)	Navy
Shelton, Robert M.	Captain	Army
Sher, Benjamin H.	Captain	Army
Sherman, Max A.	1st Lieut.	Army
Shinbane, Hyman	Captain	Army
Short, J. Edward	Captain	Army
Shotwell, Cecil LeRoy	Captain	Army
Shuman, John W., Sr.	Lt. Col.	Army
Shuman, John W., Jr.	Captain	Army
Sicherman, Karl L.	Major	Army
Silton, Maurice Z.	Lieut. (s. g.)	Navy
Silver, Bernard	Lieut. (j. g.)	Navy
Simon, Julius	Lieut. (j. g.)	Navy
Simonds, Robert	Captain	Army
Slaughter, Howard C.	Lt. Col.	Army
Sloan, Ralph V.	Captain	Army
Smaha, Joseph A.	Lieut. (s. g.)	Navy
Smallwood, Walter Charles		Navy
Smedley, Robert C.	Lt. Comdr. (inactive)	Navy
Smith, Ernest T.	Captain	Army
Smith, Harold D.	Captain	Army
Smith, Merle Anthony	Lieut.	Navy
Smith, Roy David	Lt. Comdr.	Navy
Smith, Samuel Newlan	Lieut.	Army
Smith, William W.	Lieut. (j. g.)	Navy
Snyder, William H., Jr.	Captain	Army
Soghor, Samuel	Captain	Army
Soiland, Albert	Captain	Navy
Sokol, Louis I.	Captain	Army
Soll, Sydney N.	Captain	Army
Sorenson, E. I.	Captain	Army
Southgate, Paul	Comdr.	Navy
Spalding, W. Cullen	Lt. Col.	Army
Sperling, Samuel J.	Captain	Army
Sprong, David	Major	Army
Spungin, S. A.	Captain	Army
Stanton, E. H.	Captain	Army
Stanton, Ernest Mabrey	Lieut.	Army
Stark, John Harold	Captain	Army
Starr, Wendell Wallace	Captain	Army
Staub, John G., Jr.	Lieut.	Army
Steckel, Morris Leo	Major	Army
Steele, Edson Hun	Lt. Comdr.	Navy
Stehly, Charles C.	Captain	Army
Steinman, Morris J.	Lieut.	Army
Stern, Robert Gene	Captain	Army
Stern, Robert L.	Captain	Army
Stevens, George Arnold	Lt. Comdr.	Navy
Stevens, Joseph B.	Lt. Comdr.	Navy
Stewart, Charles M.	Captain	Army
Stilwell, Leland E.	Lt. Col.	Army
Stocker, Howard O.	Captain	Army
Stout, Gurn	Lt. Comdr.	Navy
Strauss, Ludwig	Captain	Army
Sullivan, Daniel F., Jr.	Lt. Comdr.	Navy
Surber, Alva C., Jr.	Lt. Comdr.	Navy
Svec, Phillip Ernest	1st Lieut.	Army
Syman, Leo W.	Captain	Army
Szukalski, Joseph P.	Major	Army
Taber, Kenneth W.	Major	Army
Tager, Benjamin N.	Captain	Army
Tanton, Harry Alexander	Lieut. (j. g.)	Navy
Taylor, Charles M.	Captain	Army
Thomason, S. D.	Lt. Comdr.	Navy
Thompson, Harold F.	Lt. Comdr.	Navy
Thompson, Vernon P.	Major	Army
Thorner, M. C.	1st Lieut.	Army
Tidd, Charles Wharton	Lt. Comdr.	Navy
Tirrell, Walter M.	1st Lieut.	Army
Toma, John J.	Major	Army
Townsend, Kenneth	Captain	Army
Toy, Arthur J.	1st Lieut.	Army
Tragerman, Leon J.	Captain	Army
Turner, Ewing L.	Captain	Army
Tyroler, Frederic	Lieut.	Navy
Tysdale, Richard	1st Lieut.	Army
Urabec, John H.	Captain	Army
Van Cott, Wesley B.	Lt. Comdr.	Navy
Vaughn, John	Lt. Comdr.	Navy
Vento, John P.	Lt. Comdr.	Navy
Vidgoff, I. Jack	Captain	Army
Wagner, Vincent E.	Lt. Comdr.	Navy
Walker, Joe Edmund	Comdr.	Navy
Waller, Lorenz M.	Lt. Col.	Army
Ward, Henry Charles	Captain	Army
Ware, E. Richmond	Lt. Col.	Army
Warnock, Ernest Henry	Captain	Army
Warrick, R. Allison	1st Lieut.	Army
Watson, Leslie C.	Lieut.	Army

Name	*Rank* (if known)	*Service* (if known)
Watt, Richard Hugh	Lieut.	Navy
Webb, Richard F.	1st Lieut.	Army
Weber, Henry Meyer	Comdr.	Navy
Webster, George E.	1st Lieut.	Army
Weeks, Carrol L.	Captain	Army
Weinberg, Samuel J.	Captain	Army
Weinberg, Sydney L.	Major	Army
Welbourn, Leland S.	Lt. Comdr.	Navy
Welcome, Earl Howard	Colonel	Army
Westerhout, F. C.	Captain	Army
Westwater, John O.	Captain	Army
Wexler, Manuel R.	Major	Army
White, Carroll W.	1st Lieut.	Army
White, Wendell	Lieut. (j. g.)	Navy
Whitlow, Joseph E.	Major	Army
Whitsett, John W.	Lt. Comdr.	Navy
Whittaker, Thomas W.	Captain	Army
Wieman, Walter Herman	Lieut.	Navy
Wilcox, John C.	Captain	Navy
Wilkinson, Allan Blodgett	1st Lieut.	Army
Williams, Joseph B.	Lt. Comdr.	Navy
Wilson, Clinton	Major	Army
Wilson, Warren A.	Captain	Army
Wineland, Albert John	Lt. Comdr.	Navy
Winnard, Wellington F. R.	Lt. Comdr.	Navy
Wirth, Robert G.	1st Lieut.	Army
Witalis, Theodore W.	1st Lieut.	Army
Witherbee, Orville O.	1st Lieut.	Army
Witten, Paul	Lieut. (j. g.)	Navy
Wolff, Maxwell J.	Major	Army
Wolfson, I. E.	Captain	Army
Wolfson, Samuel A.	1st Lieut.	Army
Wood, Clyde O.	Captain	Army
Woodhull, F. Earl	1st Lieut.	Army
Wright, John	Comdr.	Navy
Wright, Kenneth D.	Lt. Comdr.	Navy
Wright, Wesley M.	Lt. Comdr.	Navy
Wyers, Robert E.		Army
Zide, Harry A.	Captain	Army
Zimmerman, W. T.	Captain	Army
Ziprick, Harold F.	Lieut.	Army
Ziskin, Daniel E.	Lieut.	Army
Zombro, Frederick B.	Captain	Army

XII

Marin County Medical Society

Members of the Marin County Medical Society on active duty with the Army and Navy.

(Report as of October 1, 1943. Total Number, 20.)

Cannon, Frank Mullen	Lt. Comdr.	Navy
Cleave, David C.	Major	Army
Curphey, Wilfred C.	Major	Army
Daniels, Albert Clare	Lieut. (s. g.)	Navy
Denicke, Ernest W.	1st Lieut.	Army
Everman, Cornwall C.	1st Lieut.	Army
Fowler, Donald C.	Major	Army
Goddard, A. B.	1st Lieut.	Army
Goddard, Wilson P.	Lt. Comdr.	Navy
Hammond, Howard, Jr.	1st Lieut.	Army
Hawkins, Joseph O.	Captain	Army
Hensler, Harry N.	Lt. Comdr.	Navy
Larsen, Leonard H.	Captain	Army
Marple, Charles D.	1st Lieut.	Army
Reynolds, William J.	1st Lieut.	Army
Robinson, Louis L.	Captain	Army
Schwarz, Alfred J.	Lt. Col.	Army
Schwarz, Hubert F.	1st Lieut.	Army
Stanley, Leo L.	Comdr.	Navy
Thuesen, Andrew E., Jr.	1st Lieut.	Army

XIII

Mendocino-Lake County Medical Society

Members of the Mendocino-Lake County Medical Society on active duty with the Army and Navy.

(Report as of November 5, 1943. Total Number, 9.)

Name	*Rank* (if known)	*Service* (if known)
Bramkamp, Robert G.	Lt. Comdr.	Navy
Gericke, Otto Luke	Major	Army
Gottlieb, Jacob D.	Captain	Army
Hill, Thomas Price	Captain	Army
Porter, Marshall E.	Captain	Army
Rapaport, Walter	Lt. Comdr.	Navy
Smalley, Robert B.	Captain	Army
Toller, Rudolph B.	Lt. Comdr.	Navy
Wagner, Dallas L.	Lieut.	Army

XIV

Merced-Mariposa County Medical Society

Members of the Merced-Mariposa County Medical Society on active duty with the Army and Navy.

(Report as of November 10, 1943. Total Number, 20.)

Andrews, A. V.		Army
Brannon, Max	Major	Army
Bray, E. W.		Army
Briden, V. S.	Lt. Comdr.	Navy
Bulley, E. W.		—
Crenshaw, G. L.		Army
Fountain, W. E.	Lieut.	Navy
Gustafson, A. W.		—
Jackson, E. A.	Major	Army
Lum, P. A.		—
Maytum, H. R.	Captain	Army
McDowell, B. E.	Captain	Army
Najjar, C. C.	Lieut.	Navy
Parker, J. A.	Captain	Army
Peck, R. T.	Captain	Army
Smith, L. E.	Lieut.	Navy
Soderstrom, E. M.	Captain	Army
Sturm, A. E.		—
Werthman, P. A.		—
Woro, B.	Major	Army

XV

Monterey County Medical Society

Members of the Monterey County Medical Society on active duty with the Army and Navy.

(Report as of October 16, 1943. Total Number, 27.)

Bachrach, Reinhard Josef	Captain	Army
Blount, Lester M.	Captain	Army
Carter, M. L.	Lieut. (j. g.)	Navy
Corpe, Keith Walter	Captain	Army
David y. Malig, Joaquin Maria	Captain	Army
Davlin, L. P.	Captain	Army
Englehorn, T. D.	Captain	Army
Farr, Walter Harold	Lt. Comdr.	Navy
Gratiot, C. C.	1st Lieut.	Army
Hall, Gordon Curry	1st Lieut.	Army
Herrmann, Albert Joseph	1st Lieut.	Army
Kitchen, B. E.	Lieut.	Navy
Kocher, R. A.	Major	Army
Lawler, William Horace	Lt. Comdr.	Navy
Ledesma, S. B.	Captain	Army
McPharlin, James H.	Captain	Army
Merrill, John A.	Captain	Army
Pray, Ralph Edgar	Major	Army
Rukke, R. V.	1st Lieut.	Army
Schock, R. W.	1st Lieut.	Army
Smith, Frank Hilton	Lieut.	Navy
Stufflebam, H. M.	Lieut.	Navy

Name	*Rank* (if known)	*Service* (if known)
Swengel, Winton Franklin	Lieut.	Navy
Wadsworth, E. E.	Lieut. (j. g.)	Navy
Wessels, A. L.	Lieut.	Navy
Whiffen, Robert Albert	Lieut. (j. g.)	Navy
Williams, R. D.	Captain	Army

XVI

Napa County Medical Society

Members of the Napa County Medical Society on active duty with the Army and Navy.

(Report as of November 10, 1943. Total Number, 9.)

Argens, Richard		Army
Boggs, Robert W.		Navy
Brignoli, Walter H.	Captain	Army
Dawson, George I.	Major	Army
Hohnstein, Floyd		Navy
Pasmore, John Lane		Army
Rood, Reginald S.		Army
Williams, David B.		Navy
Wood, Clarence L.	Captain	Army

XVII

Orange County Medical Association

Members of the Orange County Medical Association on active Duty with the Army and Navy.

(Report as of November 4, 1943. Total Number, 40.)

Alne, A. E.	Captain	Army
Artress, F. Lynn	1st Lieut.	Army
Anderson, Ralph D.	1st Lieut.	Army
Bailey, Nicholas E.	1st Lieut.	Army
Bean, L. L.	Lt. Comdr.	Navy
Bruning, Edward W.	Captain	Army
Cain, E. F.	Major	Army
Cameron, Lawrence	Lieut. (s. g.)	Navy
Counter, M. H.	Major	Army
Dalton, M. A.	Lt. Comdr.	Navy
Davis, John P.	Lt. Comdr.	Navy
Duncan, Ralph	Captain	Army
Fraleigh, J. P.	1st Lieut.	Army
Hall, Henry R.	Captain	Army
Harwood, Chad M.	Lt. Comdr.	Navy
Kohlenberger, C. F. W.	Captain	Army
Kraushaar, I. N.	Lieut. (s. g.)	Navy
Larson, John A.	Lt. Comdr.	Navy
Maxwell, Harvey	Lt. Col.	Army
McDowell, Mehl	1st Lieut.	Army
Moore, Newell L.	Major	Army
Nies, A. J.	Captain	Army
Paul, C. J.	Captain	Army
Peck, S. G.	Major	Army
Phetteplace, Dale O.	Captain	Army
Price, J. B.	Major	Army
Reeder, T. P.	Captain	Army
Rhone, Thomas B.	Captain	Army
Rumph, Paul E.	Lt. Comdr.	Navy
Schroer, W. J.	Captain	Army
Tedstrom, Milo K.	Major	Army
Wade, Arthur	1st Lieut.	Army
Wade, Robert S.	Major	Army
Waters, Wayne	Lieut. (s. g.)	Navy
Westerhout, C. E.	Major	Army
White, R. E.	Captain	Army
Wightman, A. H.	Lt. Comdr.	Navy
Wilson, L. E.	Lt. Comdr.	Navy
Wood, John A.	Lt. Comdr.	Navy
Young, Dwight D.	Lt. Comdr.	Navy

XVIII

Placer-Nevada-Sierra County Medical Society

Members of the Placer-Nevada-Sierra County Medical Society on active duty with the Army and Navy.

(Report as of September 29, 1943. Total Number, 10.)

Name	*Rank* (if known)	*Service* (if known)
Benteen, F. Harry	Captain	Army
Briner, C. Conrad	Captain	Army
Dubin, Nathan A.	Captain	Army
Herrmann, W. W.	Major	Army
Karo, Harold L.	Captain	Army
Odegard, John K.	Captain	Army
Pedersen, Christian B.	Major	Army
Reed, Walker W.	Captain	Army
Topic, John R.	Captain	Army
Weddle, Robert P.	Captain	Army

XIX

Riverside County Medical Society

Members of the Riverside County Medical Society on active duty with the Army and Navy.

(Report as of November 1, 1943. Total Number, 20.)

Austin, John Harvey	1st Lieut.	Army
Barnard, James F.	Major	Army
Bear, N. K.	Lt. Comdr.	Navy
Berke, S. D.		Army
Boylan, Richard N.	Lieut.	Navy
Brown, Lawrence Edward	Lt. Comdr.	Navy
Clark, Fred A., Jr.	Lieut. (s. g.)	Navy
Corr, Phillip W.	Colonel	Army
George, Lewis C.		Navy
Hankins, Franklyn Davis	Lt. Comdr.	Navy
Hilde, Stanley N.		Army
Johnson, R. L.	Captain	Army
Martin, Hugh Hudson	Lieut.	Navy
McCarthy, Charles L.	Major	Army
Miller, Arthur	Captain	Army
Oliver, James B.	Lt. Comdr.	Navy
Pauley, Ralph E.		Army
Quick, E. D.	Captain	Army
Rue, George H.		Army
Westphal, Glenn Albert	Major	Army

XX

Sacramento Society for Medical Improvement

Members of the Sacramento Society for Medical Improvement on active duty with the Army and Navy.

(Report as of October 12, 1943. Total Number, 44.)

Ankele, Cordes Westerfeld	Major	Army
Beach, Edward Woodbridge	Lt. Comdr.	Navy
Becker, Walter Nicholas	Captain	Army
Berman, Abe	Lieut.	Army
Boscoe, Anthony Ralph	Lt. Comdr.	Navy
Briggs, Wallace Rideout	Lt. Comdr.	Navy
Chambers, Jack Valentine	Lt. Comdr.	Navy
Cole, Edwin Revere	Major	Army
Cook, Orrin S.	Lt. Col.	Army
Day, Proctor Wilson	Lt. Comdr.	Navy
Dillon, Joseph Jr.	Lieut. (s. g.)*	Navy
Dozier, Dave Ford	Captain	Army
Gourse, Aaron	Lieut.	Army
Harding, William F.	Major	Army
Henderson, Andrew M., Jr.	Captain	Army
Hopkins, Maurice Albert	Lt. Comdr.	Navy
Isoard, Max	Major	Army
Johnson, Hilding Rudolph	Lt. Comdr.	Navy
Jones, Donald J.	Captain	Army
Jones, J. Roy	Major	Army
Kanner, Harry Mitchell	Major	Army
Kellogg, Pearson	Lieut. (s. g.)	Navy
Kilroy, Dan Orville	Lieut.	Army

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* Deceased.

Name	Rank (if known)	Service (if known)
Kleinsorge, Henry Emil	Captain	Army
Koch, Peter Len	Lt. Comdr.	Navy
Lee, Frank Warne	Captain	Army
Lynch, Richard L.	Lieut.	Army
McDonnell, Curtis	Major	Army
McNeil, Donald	Lt. Col.	Army
Murphy, William Richard	Lieut. (j. g.)	Navy
Ogaard, Adolph T.	Captain	Army
Phillips, Albert Dana	Lt. Col.	Army
Prisinzano, Gandolfo	Captain	Army
Saeltzer, Dudley Victor, Jr.	Major	Army
Salvater, Max L.	Captain	Army
Sarkisian, Milton	Captain	Army
Teall, Ralph Cromwell	Major	Army
Thomas, Bert Stanford	Lt. Col.	Army
Tufts, Frank Elwood	Major	Army
Wallace, Arthur Francis	Captain	Army
Wallerius, Raymond Matthias	Lt. Comdr.	Navy
Weddle, Walter E.	Captain	Army
Wilson, Albert Charles	Lieut.	Army
Yant, James Harrison	Major	Army

Doctors James Edward Conklin and Charles Wood have served during the present war, but due to health have been returned to civilian practice.

XXI

San Benito County Medical Society

Members of the San Benito County Medical Society on active duty with the Army and Navy.

(Report as of October 7, 1943. Total Number, 3.)

Brown, Ronald Earl	Lieut.	Army (Canada)
Geen, Robert S., Jr.	Major	Army
Noland, Roy Frank	Lieut.	Army

XXII

San Bernardino County Medical Society

Members of the San Bernardino County Medical Society on active duty with the Army and Navy.

(Report as of October 11, 1943. Total Number, 43.)

Abbott, Kenneth H.	1st Lieut.	Army
Atkinson, Russell E.	Captain	Army
Beaver, M. G.	Lt. Col.	Army
Bosshardt, O. A.	Lieut.	Army
Brumbaugh, Donald H.	Lt. Comdr.	Navy
Carlson, Elmer O.	Lieut.	Army
Caygill, Wayne M.	Lieut.	Army
Cecil, James J.	Major	Army
Ching, Marcus C.	Captain	Army
Ching, Samuel	Captain	Army
Clock, Charles J.	Captain	Army
Cover, William L.	Lieut. (s. g.)	Navy
Crowley, Francis L.	Lieut. (s. g.)	Navy
Downs, Howard S.	Lieut.	Army
Ford, T. F.	Lieut. (s. g.)	Navy
Gentry, H. G.	Major	Army
George, Arthur E.	Captain	Army
Gladen, Ralph C.	Lieut.	Army
Greedy, P. V.	Lt. Comdr.	Navy
Green, R. C.	Major	Army
Hayhurst, Joseph S.	Captain	Army
Helstrom, Gordon L.	Captain	Army
Hodgin, Robert I.	Captain	Army
Hoff, Cecil W.	Captain	Army
Hull, Eugene H.	Lt. Comdr.	Navy
Jacobson, Leland C.	Captain	Army
Langer, Joseph	Captain	Army
Lawrence, N. B.	Captain	Army
Melone, Frank C.	Lieut. (s. g.)	Navy
Miano, Ben D. A.	Lieut. (s. g.)	Navy
Nelson, H. Milford	Captain	Army
Neubert, A. D.	Major*	Army
Reznick, Samuel	Captain	Army
Root, Ralph N.	Captain	Army
Savage, James R.	Captain	Army
Savage, Philip M., Jr.	Captain	Army
Taylor, L. M.	Major	Army
White, Marcus D.	Colonel	Army
Williams, Delbert B.	Lt. Comdr.	Navy
Williams, Robert N.	Lieut. (s. g.)	Navy
Williamson, Robert G.	Lieut.	Army
Zelman, Julius	Captain	Army
Zelman, Samuel	Captain	Army

XXIII

San Diego County Medical Society

Members of the San Diego County Medical Society on active duty with the Army and Navy.

(Report as of September 30, 1943. Total Number, 109.)

Alberty, W. M.	Lt. Comdr.	Navy
Banks, G. F.	Major	Army
Beadner, Sol A.	Lieut.	Navy
Bernardini, C. V.	Lt. Col.	Army
Bormann, E. L.	Lieut.	Army
Bostwick, Jack	Lieut. (j. g.)	Navy
Bruner, C. William	Lieut.	Army
Callaway, J. W.	Major	Army
Cantoni, A. J.	Lieut.	Navy
Chapman, H. J.	Lt. Comdr.	Navy
Ching, C. M. S.	Lieut.	Army
Christopherson, E. H.	Major	Army
Churchill, A. G.	Comdr.	Navy
Colby, E. G.	Colonel	Army
Cooper, A. J.	Major	Army
Corbin, Damon E.	Captain	Army
Denny, Lorin W.	Captain	Army
Egan, A. R.	Captain	Army
Eneboe, J. B.	Lieut.	Navy
Fehlman, F. H.	Major	Army
Fetter, E. M.	Lt. Comdr.	Navy
Findlay, F. M.	Major	Army
Flaiz, J. W.	Lieut. (j. g.)	Navy
Giovanazzi, J. E.	Lieut. (j. g.)	Navy
Glazier, McCleary	Lieut.	Navy
Gribble, Robert C.	Lieut.	Army
Hanna, C. M.	Major	Army
Harbaugh, O. S.	Lt. Col.	Army
Harsh, George F.	Lt. Comdr.	Navy
Hartsough, C. W.	Lt. Comdr.	Navy
Helming, O. C.	Major	Army
Herbert, W. R.	Captain	Army
Hoffman, R. L.	Captain	Army
Holder, H. G.	Lt. Col.	Army
Housvicka, O. A.	Colonel	Army
Jetton, J. A.	Captain	Army
Kelley, E. H.	Lt. Comdr.	Navy
Kilgore, George L.	Major	Army
King, Ralph M.	Lieut.	Navy
Kirby, Edwin G.	Captain	Army
Kirwin, J. J.	Captain	Army
Knott, J. I.	Major	Army
Kotler, M. J.	Captain	Army
Laird, George	Captain	Army
Lane, C. W.	Comdr.	Navy
LeDuc, I. E.	Captain	Army
Lester, David	Lt. Comdr.	Navy
Levy, E. I.	Lieut.	Army
Lewis, W. M.	Lieut.	Army
Lindholm, R. C.	Captain	Army
Lindsay, C. V.	Major	Army
Lounsberry, C. R.	Comdr.	Navy

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* Deceased.

Name	Rank (if known)	Service (if known)
Lucic, L. H.	Comdr.	Navy
Macpherson, F. L.	Comdr.	Navy
Macpherson, J. D.	Lt. Comdr.	Navy
Maggio, G. E.	Lieut.	Army
Maguire, F. J.	Lieut. (j. g.)	Navy
Maguire, J. M.	Lieut.	Army
Marlow, A. A.	Major	Army
Martin, P. L.	Captain	Army
Marsden, C. S., Jr.	Captain	Army
Matson, J. R.	Captain	Army
McBride, J. P.	Lieut.	Navy
McGee, William C.	Lt. Comdr.	Navy
McIver, Robert	Captain	Army
Mehlin, G. B.	Lt. Comdr.	Navy
Miller, Edward R.	Captain	Army
Milton, J. T.	Lt. Comdr.	Navy
Minna, J. B.	Major	Army
Moffitt, L. W.	Captain	Army
Morris, G. W.	Captain	Army
Mullenix, R. B.	Major	Army
Newton, H. D.	Lt. Comdr.	Navy
O'Farrell, Norman	Lieut.	Army
O'Hara, F. P.	Lt. Comdr.	Navy
Olds, John W.	Lieut.	Navy
Osborne, C. J.	Captain	Army
Palevsky, Samuel W.	Lieut.	Navy
Paull, Ross	Colonel	Army
Phalen, J. R.	Lieut.	Army
Plagens, George M.	Lieut.	Army
Pollack, J. V.	Lieut.	Army
Present, A. J.	Major	Army
Pyle, Ross	Lieut. (j. g.)	Navy
Ravenscroft, J. W.	Lieut.	Navy
Redell, John C.	Lt. Comdr.	Navy
Rees, Charles W.	Lt. Comdr.	Navy
Reeves, M. E.	Lieut.	Navy
Richey, T. C.	Lieut.	Army
Robinson, F. H.	Captain	Army
Ryan, W. J.	Lt. Comdr.	Navy
Schlappi, J. C.	Lt. Comdr.	Navy
Seiler, W. E.	Captain	Army
Smith, W. S.	Captain	Army
Sumerlin, H. S.	Lt. Comdr.	Navy
Svoboda, F. C.	Major	Army
Tancredi, Chester	Captain	Navy
Thomas, J. W.	Lieut.	Navy
Toomey, F. E.	Lt. Comdr.	Navy
Ullrich, F. D.	Captain	Army
Weatherman, Harold	Lieut.	Navy
Wedgewood, P. E.	Lieut.	Navy
Werden, D. H.	Lt. Comdr.	Navy
West, Francis E.	Lieut.	Army
Whitelock, T. S.	Captain	Army
Wilson, I. H.	Lieut.	Army
Young, E. L.	Captain	Army
Yuskis, Anton S.	Lieut.	Navy
Zukovich, G. E.	Captain	Army

XXIV

San Francisco County Medical Society

Members of the San Francisco County Medical Society on active duty with the Army and Navy.

(Report as of October 6, 1943. Total Number, 361.)

Name	Rank (if known)	Service (if known)
Abramson, Arthur J.	Captain	——
Adams, George F.		Army
Agmar, Albert Ringstrom		Navy
Albi, Piero		Army
Anderson, Edmund F.	Captain	Army
Antipa, August		Army
Arnowitz, Isaac	1st Lieut.	Army
Ashley, Rea Ernest	Captain	Navy
Auerbach, Joseph	Major	Army
Bailly, Thomas E.		Navy
Baker, George L.		Army
Barrett, William G.	Major	Army
Bazzano, John J.		——
Beare, William K.	Captain	Army
Benioff, Mortimer A.		Army
Bennett, Dudley W.		Navy
Berger, Adolphus A.		——
Bernstein, Abraham	Lt. Col.	Army
Best, Elbridge John		Navy
Birnbaum, Walter D.	Major	Army
Bonar, Perry A.		Navy
Borley, William Edgar		Navy
Boudett, Daniel W.	Lieut.	Army
Brinckerhoff, Albert Johnson		Navy
Brindamour, Jean L.		Army
Brown, Albert Lincoln	Lt. Comdr.	Navy
Brown, Harrison Cabot	Lt. Comdr.	Navy
Brown, John Lawrence		Navy
Brown, John W.	Lieut.	Army
Bruckman, Frederick S.		Army
Burkhard, William George		Navy
Burnham, De Witt Kinne	Comdr.	Navy
Cameron, William M.		Army
Campion, Edward	Major	Army
Campion, George S.	Lieut.	Navy
Card, John Ford		Navy
Carman, Henry F.		Army
Carson, Donald A.		Navy
Cary, William S.		Navy
Charmak, David D.	Lt. Comdr.	Navy
Cheney, Garnett	Lt. Col.	Army
Cherney, L. S.	Captain	Army
Christierson, Sigurd von		Navy
Clark, Albert G.		Army
Cohn, Herbert J.		——
Cohn, Roy		Army
Cohn, Samuel		Navy
Colloff, Benjamin		——
Colman, Maurice		Army
Cooper, Charles E.		Navy
Courtright, Lazarre John		Army
Cox, Thomas J.	Lieut. (s. g.)	Navy
Cronin, Daniel Joseph		Army
Cullen, Edward R.	Lieut. (j. g.)	Navy
Cushman, Glenn Ford		Navy
Custer, Lawrence R.	Lt. Col.	Army
Cutler, Charles H.	Lieut.	Army
Dallas, Donald Alexander		Navy
Darling, Herbert H.		Army
Davis, H. Clarke		Army
Davis, Joseph Harold		Army
Day, Boston M.		——
Dewey, Earle T.	Lt. Comdr.	Navy
Doyle, Gerald Francis		Navy
Drake, James Richard	Captain	Army
Drees, Lawler Adolph	Lt. Comdr.	Navy
Driscoll, John Albert		Navy
Dryfoos, Herbert L.		Army
Duggan, Richard J.	Captain	Army
Duggan, William Thomas		Navy
Egleston, E. Francis		Army
Eliaser, Maurice	Captain	Army
Escamilla, Roberto	Major	Army
Fahlen, Charles Cuthbert	1st Lieut.	Army
Feldheym, Jean S.		Army
Fine, Max	Captain	Army
Fishbon, Harris Mayer	Captain	Army
Fitzhugh, William McPherson, Jr.		Navy
Fletcher, Charles Dannenbaum		Navy
Fletcher, Russell	Lt. Comdr.	Navy
Flinn, Edward F.		Navy
Fogerty, Clement A.	Lt. Col.	Army
Fong, Edward E.	1st Lieut.	Army

Name	*Rank* (if known)	*Service* (if known)
Foote, Frederick S.		Navy
Fraser, Harold E.	Lt. Comdr.	Navy
Fregeau, Aime Napoleon	Comdr.	Navy
Fricke, John William	Lieut. (s. g.)	Navy
Friedell, Hymer L.	Captain	Army
Friedlander, R. D.	Major	Army
Friedman, Meyer	Captain	Army
Friedman, Nathan B.	Lieut.	Army
Fullenlove, Thomas M.	Captain	Army
Fulton, Lee D.		Army
Gardenier, Crane		Army
Gardner, Alfred Emmons		Army
Garfield, F. Edwin	Lt. Comdr.	Navy
Garland, Leo Henry	Lt. Comdr.	Navy
Gassman, Frank Carl		Army
Gates, Claudius Y.		Army
Gauthier, August Eugene	Captain	Army
Gay, LeRoy K.		Navy
Gaynor, Edmund Patrick		Navy
Gerbode, Frank L. A.		Army
Gershanov, Edward Melvin	1st Lieut.	Army
Gibbons, Morton R. Jr.	Lieut.	Navy
Gilman, Philip K.	Captain	Navy
Glukfeld, Jerome P.		Army
Godwin, Edmund D.		Army
Gold, Rubin L.	Lieut.	Army
Goldman, Alfred	Lieut.	Navy
Goldstein, Louis B.	Major	Army
Gordan, Gilbert S.	Captain	Army
Gordon, Morris R.	Captain	Army
Greene, William Wallace		Army
Grodsky, Lewis I.	Major	Army
Groper, Morris J.		Army
Guttentag, Otto Ernst	Captain	Army
Hall, Samuel Pike	Lieut. (j. g.)	Navy
Halter, Bert L.		Army
Hand, Harold Michael	Lt. Comdr.	Navy
Hand, Mark	Major	Army
Hanten, John S.		Navy
Harmon, Ellis Drew	Major	Army
Harrall, Pinckney	Lieut.	Navy
Harrington, David O.	Lt. Comdr.	Navy
Harrington, Harrel Lee		Navy
Harrison, Marlow B.	1st Lieut.	Army
Hartwig, Carl H.		——
Hatlelid, Frank H.	Captain	Army
Hause, Edward Earle		Navy
Hayden, Charles Thomas	Lt. Comdr.	Navy
Haymaker, Webb E.	Captain	Army
Hazel, James K.		——
Healy, Edward F.		——
Hein, Gordon E.		Army
Helsley, Gordon F.	Lt. Col.	Army
Henning, Berthel H.	Major	Army
Heppner, Myer J.		Army
Herzog, George K., Jr.		Army
Hess, Rolla B.		Army
Hill, Harold A.	Comdr.	Navy
Hodges, Francis T.		Navy
Hodgson, H. Marvin	Captain	Army
Hoffmann, Paul E.		Navy
Hogan, Michael John		Navy
Holko, John E.		Army
Holman, Emile Frederic	Comdr.	Navy
Hope, John Westgate		Navy
Hopp, Eugene Samuel	Major	Army
Horner, Warren Douglas	Captain	Navy
Hosmer, Matthew N.		Navy
Howard, Francis Emmert	Lieut. (j. g.)	Navy
Howard, Harry Patterson	Lieut.	Army
Howard, Lott Duncan	Captain	Army
Ice, William H.	Major	Army
Impey, Charles C.		——
Iverson, Jesse Joseph		Army
Jacks, Francis M.		Army
Jacobs, Alvin Hirsch		Navy
Jaekle, Russell F.	Major	Army
Johanson, Vincent E.	Captain	Army
Johnson, Clark Moore		Navy
Johnson, Phillips	Major	Army
Jones, Richard B.		Army
Kaarboe, Olaf	Major	Army
Kandel, Alfred		——
Kansora, Clement Paul	Captain	Army
Keenan, Peter J.	Lieut.	Navy
Keig, William C.		Navy
Kelley, Douglas M	1st Lieut.	Army
Klabunde, E. Horace		Army
Klein, Russell R.		——
Konigsburg, Jerome		Army
Lachman, George Sydney	Lt. Comdr.	Navy
Lastreto, E. Donald	Lieut. (j. g.)	Navy
Lawler, Thomas Gorman	1st Lieut.	Army
Leeds, Sanford	Captain	Army
Leef, Edward		Navy
Leimbach, John H.	1st Lieut.	Army
Leland, Sherman	Lt. Comdr.	Navy
Lenahan, George T.		Army
Lennon, Thomas J.		Army
Leonard, Maurice E.		Army
Lestrohan, Paul F.		Navy
Leveton, Albert Louis Isaiah	Captain	Army
Levin, Edward Alexander		Army
Levitin, Joseph	Lt. Col.	Army
Lindner, Harold		Army
Louie, Stanley		Army
Loutzenheiser, John J.		Army
Lowe, Frank A.		Navy
Lusignan, Frank W.		Army
Madlem, Leo S.	Lieut. (j. g.)	Navy
Magee, Thomas Lea 2d	1st Lieut.	Army
Mahon, Edmund Joseph	Lt. Comdr.	Navy
Maisler, Sol	Lt. Comdr.	Navy
Manjos, Peter		Army
Marasco, Fred Bernard	Captain	Army
Marks, Roland F.	Lt. Col.	Army
Marquis, Harold H.		Army
Masters, Elson Jacob		Army
Mathews, Benton D.	1st Lieut.	Army
Mathewson, Carleton		Army
Matzger, Edward		Navy
McDowell, Arthur	Lt. Comdr.	Navy
McGuinness, John E.	Captain	Army
McGuinness, Joseph Stanley	Major	Army
McKenney, Arthur C., Jr.		Navy
McRae, Colin C.		Navy
Meherin, J. Minton		Navy
Mensor, Merrill Coleman		Navy
Merritt, Robert E.	1st Lieut.	Army
Michael, Michael T.		Navy
Michels, Leon M.		Army
Miller, George B.		——
Miller, Ivan Jenks	Major	Army
Miller, John Johnston, Jr.		Navy
Millzner, Raymund J.	Major	Army
Mohr, Selby Rudolph, Jr.		Navy
Mohun, Charles Constantine, Jr.	1st Lieut.	Army
Morgan, John E.		——
Morgenstern, Hymen Sidney		Army
Morris, Raymond Legrand		Navy
Mote, Clayton Daniel		Army
Munter, Edgar J.		——
Myers, Philip	Lieut. (j. g.)	Navy
Nagle, John Michael	Lt. Comdr.	Navy
Nelson, Clarence	1st Lieut.	Army
Newgard, Kurt W.		——

Name	Rank (if known)	Service (if known)
Newman, Henry Wise		Navy
Newman, William W.		Navy
Nolan, Oscar Frederick	Lt. Col	Army
Northway, Frederick J.		Army
Nuyens, Louis Cornelius	Captain	Army
Nyda, Morton J.		——
O'Connor, Gerald Brown		Navy
O'Connor, Samuel		Army
O'Grady, William Edward		Army
Oliver, Wrenshall A.		Navy
Osipow, Samuel		Army
Overstreet, Edmund William		——
Paoli, Theodore Henry	Captain	Army
Parker, Leon O.		Navy
Parkinson, Harold Obediah		Army
Paul, Sarkis Barre		Navy
Penn, Lloyd Lyttleton		Navy
Petrilli, Alexander	Lieut	Navy
Pflueger, Otto Henry	Captain	Army
Poliak, Percy P.		Navy
Polse, Max L.		Army
Porporato, A. J.	Lieut. (s. g.)	Navy
Poulsen, Theodore S.	Lieut. (j. g.)	Navy
Poy, William Jue		Army
Pratt, Donald R.		Army
Prescott, M. U.	Lt. Col	Army
Quinlan, John F.		Army
Quinn, William Joseph		Army
Ratner, Reuben	Captain	Army
Reed, Karl A.	Lt. Comdr	Navy
Reilly, William Anthony	Lt. Col	Army
Reinhardt, Paul Henry		Navy
Rew, Kenneth	Major	Army
Reynolds, John L.	Lieut. (s. g.)	Navy
Reynolds, Lloyd R.		Navy
Rhodes, George K.	Lt. Col	Army
Rice, Frank Manuel		Navy
Riechel, Leslie	Captain	Army
Rixford, Emmet		Navy
Roberts, Thomas Haynes	1st Lieut	Army
Robinson, J. Maurice		Navy
Robson, George Bernard	Major	Army
Rochex, Francis	Captain	Army
Rogers, William Lister	Lt. Comdr	Navy
Rosenberg, Ralph	Captain	Army
Rosenblum, Harold Herbert	Lt. Comdr	Navy
Rothmann, Hans	Captain	Army
Rustad, William H.	Captain	Army
Ryan, Andrew M.		Army
Sawyer, Lester		Army
Scarborough, Robert Alexander		Navy
Schneider, Elliott G.		Navy
Schomaker, Theodore Paul		Army
Schumacher, Irwin C.	Lt. Col	Army
Schwartz, Irving		Army
Scott, Wirt S.		Army
Scovel, Ralph Edwin	Lt. Comdr	Navy
Sears, Adrian R. M.	Lieut. (j. g.)	Navy
Seely, Hall	Major	Army
Shapiro, Newton Hart		——
Shea, J. Frank		Army
Sherman, Robert Stanton	Lieut. (j. g.)	Navy
Sherman, Samuel R.	Lieut. (s. g.)	Navy
Shidler, Frederic Porter		Navy
Shone, Lloyd Bertram		Navy
Shumate, Charles A.		——
Simpson, Roger		Army
Sinclair, Archie D.	Captain	Army
Sirbu, A. B.	Lt. Col	Army
Sleath, Jack C.		——
Smart, Bret W.		Army
Smith, Gregory		Navy
Smith, Richard Clifford		Navy
Smith, Seymour P.	Lieut. (s. g.)	Navy
Sokolow, Maurice		Navy
Solomon, Joseph C.		Army
Soto-Hall, Ralph		Army
Spencer, Alfred George		Navy
Spencer, John A.		Army
Spitalny, August		Navy
Steiss, Charles F.		Navy
Stephens, H. Brodie	Major	Army
Steven, Robert A.		Army
Stiles, Frank E.		Army
Stockton, Andrew Benton	Lt. Comdr	Navy
Strauss, Bernard	Captain	Army
Strong, Kenneth	Major	Army
Sugarman, Harold		Army
Sullivan, Bernard James		Navy
Sullivan, James M.	Lt. Col	Army
Sumner, William Artell	Lt. Comdr	Navy
Susnow, David Abram		Navy
Swanson, Marion Alan		Navy
Sweigert, Charles Francis	Major	Army
Tavares, Clement A.	Major	Army
Teitler, Max H.	Captain	Army
Torre, Emile David		Navy
Tucker, Sidney N.	Major	Army
Turkel, Abraham W.	Lieut. (s. g.)	Navy
Unsinger, Harold Farquhar	Captain	——
Upton, John Roland	Captain	Army
Van Deventer, William C.		Army
Viecelli, James D.		Navy
Viguie, George Charles		——
Vincent, Glen P.		Army
Vogel, Philip		——
Von Dessonneck, Emil	1st Lieut.	Army
Wagner, Richard Joseph		Navy
Wagner, Robert L.		Navy
Wald, Horace A.		Army
Watson, Harold Gladstone	Lt. Comdr	Navy
Wayburn, Edgar		Army
Weber, Walter M.		Navy
Weinstein, Harry		Army
West, Jesse H.	Captain	Army
Weyrauch, Henry M.		Navy
Whalen, Thad John		Navy
White, Alfred S.		Army
Whitsell, Leon J.		Navy
Wilbur, Dwight Locke	Lt. Comdr	Navy
Willett, Forrest N.	Major	Army
Williams, A. Justin	Major	Army
Williams, Harry DeNell, Jr.		Navy
Wiper, Thomas B.	Major	Army
Wolf, Robert W.		Army
Wolff, Frederick Siegfried	Captain	Army
Woo, Henry Bischoff		Army
Work, Walter Paxton	Captain	Army
Wyne, Paul Samuel	Captain	Army
Zealear, David S.		Navy
Zobel, Jerome F.		Navy
Zumwalt, Reuben H.	Lieut. (j. g.)	Navy

XXV

San Joaquin County Medical Society

Members of the San Joaquin County Medical Society on active duty with the Army and Navy.

(Report as of September 29, 1943. Total Number, 38.)

Anderson, E. A.		Army
Auld, W. T.	Lieut	Army
Barbour, N. P.	Lt. Col	Army
Blackmun, E. L.	Lieut	Army
Collis, W. H. Langley	Lt. Comdr	Navy
Den Dulk, Gilbert	Lieut	Navy

Name — *Rank* (if known)	*Service* (if known)
Dyar, Robert—Captain	Army
Eccleston, John Oliver—Captain	Army
Faulkner, Edward—Lieut. (s. g.)	Navy
Gale, L. S.—Lieut.	Army
Gallegos, P. B.—Lt. Comdr.	Navy
Ghiglieri, Louis Loyd—Lieut.	Army
Green, Marion Melvin	Army
Greenman, R. A.	Army
Halley, Edmund Paul—Lt. Comdr.	Navy
Harrington, D. C.—Captain	Army
Johnson, N. P.—Lt. Col.	Army
Lamb, P. V.—Lieut.	Army
Leiske, S. W.—(Inactive)	Army
Longley, J. E.—Lieut.	Army
Lynch, John C.—Lieut.	Navy
Maurer, R. D.—Lieut.	Navy
McGuire, Frank Alexander—Major	Army
McHugh, Patrick Henry—Captain	Army
O'Connor, Vincent Daniel—Lieut.	Army
Petersen, Henry Charles—Lieut.	Army
Powell, B. J., Jr.—(Inactive)	Army
Quinn, Henry—Lieut.	Army
Rixford, Henry Covington—Lieut. (s. g.)	Navy
Rohrbacher, G. H.—Lt. Col.	Army
Rosasco, J. L.—Lt. Comdr.	Navy
Ross, Verne R.—Lt. Comdr.	Navy
Schreiber, Julius—Lieut.	Army
Thompson, C. V.—Colonel	Army
Tretheway, L. E.—Major	Army
Tunnell, A. M.	Army
Vieira, F. G.—Lt. Comdr.	Navy
Wever, G. K.—Captain	Army

XXVI

San Luis Obispo County Medical Society

Members of the San Luis Obispo County Medical Society on active duty with the Army and Navy.

(Report as of September 29, 1943. Total Number, 5.)

Name	Service
Bingham, Elmer McKinley—Lieut. (s. g.)	Navy
Butler, Willis Dale—Lt. Col.	Army
Kennedy, Charles Robert—Captain	Army
Nay, Newell—Lieut. (s. g.)	Navy
Shershow, Albert—Captain	Army

XXVII

San Mateo County Medical Society

Members of the San Mateo County Medical Society on active duty with the Army and Navy.

(Report as of November 10, 1943. Total Number, 23.)

Name	Service
Anzinger, Paul Ernest	Army
Berry, Bard S.	Army
Borley, Roswell Donaldson	Navy
Bridgman, J. Garwood	Army
Brown, Dewey Franklin—Lt. Comdr.	Navy
Farthing, Thomas E.—Major	Army
Fox, N. G.	Army
Gamette, Evan Grose—Lieut.	Coast Guard
Glaser, Werner—1st Lieut.	Army
Hargus, H. B.	Army
Heinz, Vernet Harold	Navy
Holmes, Olin M.	Navy
Hurlbut, W. B.	Army
Karr, Martin	Army
Lagen, John	Army
Layton, W.	Army
Miller, Albert George	Army
Mills, W. W.	Army
Morrison, Gordon Monroe	Navy
Moulton, R. R.	Army
Richards, E. E.	Army
Seeley, P.	Navy
Smith, Harry	Navy

XXVIII

Santa Barbara County Medical Society

Members of the Santa Barbara County Medical Society on active duty with the Army and Navy.

(Report as of September 29, 1943. Total Number, 38.)

Name — *Rank* (if known)	*Service* (if known)
Atsatt, Rodney Fremont—Comdr.	Navy
Baird, Charles G.—Colonel	Army
Bell, Ralph M.	Army
Bissell, Arthur Dwight—Lt. Comdr.	Navy
Burtness, Hildahl Ingbert—Lt. Comdr.	Navy
Campbell, William Howard—Captain	Army
Coshow, George H.—Captain	Army
Derieux, George H.—Captain	Army
Evans, William D.—Captain	Army
Findlay, H. Verrill—Lt. Comdr.	Navy
Fiske, L. Gordon—Captain	Army
Gates, Russell—Lt. Comdr.	Navy
Graham, Walter Cheney—1st Lieut.	Army
Gray, Percival Allen, Jr.—Comdr.	Navy
Hammel, Max—1st Lieut.	Army
Helbling, Franklin K.—Captain	Army
Holcombe, Donald C.—Captain	Army
Hollister, Clinton Bennett Hale—Captain	Army
Hunt, William R.—Lt. Comdr.	Navy
Johnston, William Raby—Lieut. (s. g.)	Navy
Jones, Orion C.—Lt. Col.	Army
Kearney, Sandborn G.—Captain	Army
Lambuth, Robert W.—Captain	Army
Markthaler, Edward L.—Comdr.	Navy
McDowell, Douglas Francis—1st Lieut.	Army
McGovney, Richard B.—Major	Army
McNamara, Delbert H.—Lt. Comdr.	Navy
Missall, Albert S.—Captain	Army
Miyouchi, Yukio—1st Lieut.	Army
Nelson, Harold O.—Lieut.	Army
Patterson, Kenneth—Comdr.	Navy
Rupp, Jerome J.—Lt. Comdr.	Navy
Schmela, Woodrow W.—Captain	Army
Smith, Gordon—1st Lieut.	Army
Streaker, Lee H.—Captain	Army
Tomlinson, Wray J.—Captain	Army
Ussher, Neville Thompson—Major	Army
Wilson, Kent R.—Captain	Army

XXIX

Santa Clara County Medical Association

Members of the Santa Clara County Medical Association on active duty with the Army and Navy.

(Report as of October 5, 1943. Total Number 78.)

Name	Service
Anderson, Frank Russell	Navy
Arminini, George Bert	Army
Arnold, Harry Joseph	Army
Badami, Anthony George	Army
Barrette, Pierce Cooke—Captain	Army
Baumann, Franz W.	Army
Bethel, Robert D.—Lieut. (j. g.)	Navy
Bigotti, Richard T.—Lieut.	Army
Bilker, Daniel—Captain	Army
Billingsley, Gordon David	Army
Blanchard, Leland B.—Lieut.	Army
Brodovsky, Dan—Lieut.	Navy
Campisi, Dominic—Major	Army
Carlson, Carl O.	Army
Cassell, Irving—Lieut.	Navy
Chesbro, Wayne	Navy
Childers, Leland A.	Navy
Cilley, Herbert A.—Captain	Army
Cook, Enos Paul—Lt. Comdr.	Navy
Conroy, Thomas F., Jr.—Captain	Army
Cragin, Robert B.—Major	Army
Cressman, Ralph D.	Army
Cutter, Richard D.	Army

Name	*Rank* (if known)	*Service* (if known)
Davis, Gerald Evans	Captain	Army
Elmore, Ernest	Lieut	Navy
Fox, Leon Parrish	Lieut	Navy
Francis, Kenneth V.	Captain	Army
Geisler, William H.	Captain	Army
Gerstle, Mark, Jr.	Lt Comdr	Navy
Glyer, C. Hartley	Lieut	Navy
Haley, Philip S.	Lt. Comdr	Navy
Henderson, Emmett	Major	Army
Hockenbeamer, Ernest	Lieut	Navy
Ishikawa, Tokio		Army
Jenkins, Herbert W.		Army
Jones, Theodore Clifton	Captain	Army
Jorgensen, Milford		Army
Josephson, Joseph B.	Lt. Comdr	Navy
King, Robert W.	Captain	Army
Lane, Henry		Navy
Lane, Robert Daniel	Lieut	Navy
Lawry, Edwin V.		Navy
Lee, Russel Van Arsdale	Major	Army
Liston, Edward	Captain	Army
Loehr, Robert Allen	Lieut	Navy
Leonard, Carl D.		Army
Lyon, Thomas P.	Major	Army
Lytle, H. W.		Navy
Magoon, Leslie B.	Lieut	Navy
Maher, Edward J.		Army
Mason, Marshall Irwin	Captain	Army
Melkonian, Leon	Lt. Comdr	Navy
Mitchell, Sidney P.	Lieut	Navy
Moore, Ferrall H.	Lt. Comdr	Navy
Morehead, Marvin G.	Lieut	Army
Muir, James C.	Lieut	Navy
Norberg, Raymond W.		Army
Pace, Paul Theron	Captain	Army
Pettit, Richard D.	Lieut	Army
Pfaff, Richard O.	Lieut	Navy
Pickworth, Max E.	Major	Army
Premo, Milton	Lieut	Army
Pritchard, Jacob L.	Lt. Col	Army
Rehm, Mary J. Hoag	Lieut. (j. g.) (Waves)	Navy
Rogozen, Alexander		British Service
Rouff, Elliot	Lieut	Navy
Rutherford, Findlay de Paul	Lieut	Navy
Salvadorini, Vasco	Lieut	Navy
Sullivan, Cletus S.	Lt. Comdr	Navy
Threlfall, Donald R.	Captain	Army
Tucker, Hymen	Major	Army
Vogelman, Jack George	Lieut	Navy
Waters, George W.	Captain	Army
Williams, Alvin Buerlen	Lieut	Navy
Wilson, John C.	Lieut	Navy
Wood, Denniston, Jr.		Navy
Wood, George		Army
Wright, Ralph W.		Army

XXX

Santa Cruz County Medical Society

Members of the Santa Cruz County Medical Society on active duty with the Army and Navy.

(Report as of October 4, 1943. Total Number, 14.)

Name	*Rank* (if known)	*Service* (if known)
Allegrini, A. E.	Lieut	Navy
Alsberge, Richard Carey	Captain	Army
Eiskamp, Ehler H.	Lt. Comdr	Navy
Fleming, G. L.	1st Lieut	Army
Gilman, P. K., Jr.	Lt. Comdr	Navy
Harrington, J. T.	Lt. Comdr	Navy
Havenhill, A. D.	Major	Army
Jacobson, J. C.	Captain	Army
Ludden, Jerome Adlbert, Jr.	Lieut. (j. g.)	Navy
Maeth, David	Captain	Army
Pederson, A. J.	Lieut	Navy
Smith, Daniel Denver	Lieut. (j. g.)	Navy
Thomas, Henry S.	Captain	Army
Wood, Avery Edwin	1st Lieut	Army

XXXI

Shasta-Trinity County Medical Society

Members of the Shasta-Trinity County Medical Society on active duty with the Army and Navy.

(Report as of October 2, 1943. Total Number, 8.)

Briggs, John Douglas		Army
Henry, Amos Raymond	1st. Lieut	Army
Jantzen, Roland Regahl		Army
Kahn, Harold	Captain	Army
Katz, Leonard		Army
Marchus, Donald Barber	Captain	Army
Murphy, Morton James	Major	Army
Trelstad, Bertram Lawrence	Major	Army

XXXII

Siskiyou County Medical Society

Members of the Siskiyou County Medical Society on active duty with the Army and Navy.

(Report as of October 27, 1943. Total Number, 2.)

Hayden, Wilbur C.	Captain	Army
Vidrickson, Harry L.	Lt. Comdr	Navy

XXXIII

Solano County Medical Society

Members of the Solano County Medical Society on active duty with the Army and Navy.

(Report as of November 1, 1943. Total Number, 5.)

Dockendorff, William G.		Navy
Fort, Walter A.	Captain	Navy
Gibbons, Harold		Navy
Lockhart, Jesse		Navy
Porter, Joseph I.	Comdr	Navy

XXXIV

Sonoma County Medical Society

Members of the Sonoma County Medical Society on active duty with the Army and Navy.

(Report as of October 2, 1943. Total Number, 19.)

Brink, Holden	Lieut. (s. g.)	Navy
Clary, Raimond F.	Captain (Inactive)	Army
Congdon, Gordon Hall	Lieut	Army
Dunlavy, Kenneth James	Captain	Army
Harr, Ralph Verling	Lt. Comdr	Navy
Hines, Leonard A.	Major	Army
Koerper, Victor E.	Lieut	Army
Lewis, Wayne	Captain	Army
Meyer, Emerson L.	Captain	Army
Nunes, Aubrey J.	Lieut. (j. g.)	Navy
Quarry, Paul T.	Lt. Comdr	Navy
Rolph, Ronald J.	Lieut	Army
Rudee, William Jen	Lieut. (j. g.)	Navy
Sohler, Frank E., Jr.	Major	Army
Stimson, Clement	Lieut. (s. g.)	Navy
Thurlow, John Fuller	1st Lieut	Army
Torgerson, Thomas Myron	Major	Army
Ward, Thomas A.	Lieut	Army
Zieber, Roscoe Lee	Lt. Comdr	Navy

XXXV

Stanislaus County Medical Society

Members of the Stanislaus County Medical Society on active duty with the Army and Navy.

(Report as of October 6, 1943. Total Number, 16.)

Collins, James Wallace	Lieut	Army
Custer, C. P.	Captain	Army

Name	*Rank* (if known)	*Service* (if known)
Husband, R. D.	Major	Army
Jackson, Albert Leonard	Lieut.	Navy
Laird, Terry	Lieut.	Navy
Maino, C. R.	Lieut.	Navy
Morris, John K., Jr.	Captain	Army
Morrison, A. F.		——
Radcliff, Robert	Lieut.	Army
Robertson, Donald	Captain	Army
Sherertz, Richard	Captain	Army
Steele, Warren	Captain*	Army
Stewart, H. B.	Captain	Army
Van de Pol, Andrew	Lieut.	Army
Wilson, Harris	Captain	Army
Wissner, Leonard Otto	Lieut.	Navy

XXXVI

Tehama County Medical Society

Members of the Tehama County Medical Society on active duty with the Army and Navy.

(Report as of October 6, 1943. Total Number, 1.)

Wood, Otho Townsend	Lieut.	Navy

XXXVII

Tulare County Medical Society

Members of the Tulare County Medical Society on active duty with the Army and Navy.

(Report as of October 11, 1943. Total Number, 16.)

Barber, Philip S.	Lt. Comdr.	Navy
Blasdel, Edward K.	Captain	Army
Brady, John H.	Lieut. (j. g.)	Navy
Clinite, W. D.		——
Cooley, Fred E.		——
Cronemiller, Ray Edward	1st Lieut.	Army
De Busk, Fred G.	Lt. Col.	Army
Falk, Harry	Major	Army
Ireton, W. S.		Army
Johnson, Cyril H.		Army
McKinnon, D. C.		Navy
Miller, Palmer Donald	1st Lieut.	Army
Parkinson, W. D.	Captain	Army
Powell, Forrest G.	Captain	Army
Zink, Wiley		Army
Zumwalt, E. K.	Lt. Col.	Army

XXXVIII

Ventura County Medical Society

Members of the Ventura County Medical Society on active duty with the Army and Navy.

(Report as of November 1, 1943. Total Number, 20.)

Achenbach, L. H.	Lt. Comdr.	Navy
Anderson, E. R. V.	Lt. Comdr.	Navy
Clark, Daniel M.	Lt. Comdr.	Navy
Clark, W. Sterling	Major	Army
Cruden, A. W.		Army
Cutts, F. W.		Army
Daly, J. Austin	1st Lieut.	Army
Gallison, Frank		Navy
Garrett, F. H.		Army
Gibbons, Joel		——
Harker, R. K.		Army
Huff, W. C.		Army
Moore, James W.	Lieut.	Navy
Morrison, A. A.	Comdr.	Navy
Nielsen, J. W.		——
Renger, J. J.	Captain	Army
Scherb, R. F.		Army
Sizer, E. R.		Army
Vincent, Ward	Lieut. (j. g.)	Navy
Wylie, C. R.		——

XXXIX

Yolo County Medical Society

Members of the Yolo County Medical Society on active duty with the Army and Navy.

(Report as of September 30, 1943. Total Number, 12.)

Name	*Rank* (if known)	*Service* (if known)
Burns, Robert A.	Lieut.	Army
Copeland, Edwin K.	Lt. Comdr.	Navy
Frost, David	Lieut.	Army
Goerke, Lenore S.	Major	Army
Graeser, Henrik	Major	Army
Gray, Earl H.	Lt. Col.	Army
Potter, Henry G.	Lieut.	Army
Robbins, Wilfred T.	Lieut.	Army
Roller, Charles S.	Lt. Comdr.	Navy
Rovane, John	Captain	Army
Waters, Max A.	Captain	Army
Wilmes, Malcolm	Major	Army

XL

Yuba-Sutter-Colusa County Medical Society

Members of the Yuba-Sutter-Colusa County Medical Society on active duty with the Army and Navy.

(Report as of November 29, 1943. Total Number, 10.)

Delamere, Granville Sinclair	Lt. Col.	Army
Hamilton, Lucian R.	Major	Army
Hennessey, Harold R.	Major	Army
Kimmel, Charles	Major	Army
Miller, Benjamin F.	Captain	Army
Morris, Samuel	Major	Army
Ornduff, William		Army
Parkinson, S. R.	Captain	Army
Swift, Leon	Captain	Army
Thunen, Philip E.	Captain	Army

CALIFORNIA MEDICAL ASSOCIATION
1957

Service Flag
of the
California Medical Association
As of September, 1943, the roster contained 1,957 names.
In December, military colleagues numbered 2,055.

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* Deceased. Plane crash.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Office of War Information Says Casualties Cut By New Treatments: Wounded Have 96 to 100 Chances to Survive

More Killed Outright Than in 1918 Because Weapons Deadlier, Survey Shows; Shock Cures Increase

Modern weapons are twice as deadly as the guns of 1917-1918, but the 1943 casualty who is not killed outright has about twice as much chance to survive as the wounded man of World War I.

The Office of War Information (OWI) has reported in the first comprehensive survey of care of the war wounded that the service man who "stops one" has better than ninety-six chances in one hundred to survive his wounds in this conflict.

Shock and infection were the great killers of the wounded in 1917-1918. In the present war, blood plasma transfusions greatly reduce the shock danger, and the sulfa family drugs have minimized the possibility of infection, both the Army and Navy reported.

BETTER TREATMENT

Better and faster treatment of the wounded also play a major part in reducing deaths from wounds. Both the Army and the Navy have revised their procedures for attending wounded men, having moved dressing stations almost up to the front lines.

"In the last war, wounded men were brought to the hospital," the OWI reports; "in this war, the hospital goes to the wounded men."

Army records show that only thirty-five out of every 1,000 men wounded now succumb to their battle injuries, compared with a death rate of 60 per 1,000 in the last war. The Navy now loses only 31.6 men in each 1,000 wounded, less than half the 73.5 who died of wounds in 1917-1918. The Marine Corps reports 31.5 deaths per 1,000 wounded, down from the 120 deaths per 1,000 recorded a quarter century ago.

DEADLY POWER

One soldier was killed by 1918 weapons for every six wounded. The deadly power of today's weapons is shown by the fact that one soldier is killed for every three wounded. Navy records show a ratio of one killed to one-plus wounded (6,076 dead and 7,810 wounded at the time of the survey), which is twice the rate of World War I days.

Between 50 and 60 per cent of men who suffered head wounds died in 1917 and 1918. Deaths from head wounds have been cut to 9 per cent in the current war, due to plasma and sulfa treatments.

In North Africa, 400 sailors were badly burned when their ship exploded. Under World War I conditions, 100 would have died within forty-eight hours. Only four of the 400 died, due to prompt treatment with plasma.

AMPUTATIONS REDUCED

The survey also noted that the percentage of necessary amputations has been reduced in this war, because of reduced infection and hemorrhage.

The pain of wounds is also greatly minimized now through the more widespread use of morphine syrettes, which even an inexperienced man can use.

The present conflict is a tougher war all around than the first World War.

The greater incidence of mental breakdowns is due to the increased strain and danger of the campaigns.

Hospital admissions for mental ailments averaged between twenty and thirty per 1,000 per year twenty-five years ago, but the rate is up to between fifty and sixty per 1,000 in this war. In some particularly rugged theaters of war, 20 to 25 per cent of all hospital admissions are mental cases.

The survey reported that men are kept in action for longer periods without relief in this war, which contributes to nervous ailments.

Psychiatric treatment in the front areas, however, has been found much more effective in treating war-induced mental ills than the methods used to treat shell shock twenty-five years ago. From 50 to 70 per cent of the neuropsychiatric are returned to combat duty after front-area treatment, whereas in 1917-1918 only a handful of shell-shock victims recovered sufficiently to return to action.

Armed Services Reveal Needs in Medical Corps

Seven Thousand More Sought by Army and Navy During This Year

Washington, Oct. 20 (UP).—The Office of War Information revealed tonight the Army and Navy require an additional 7,000 medical officers and 800 dentists to care for the wounded through December 31 as minimum insurance against all battle emergencies.

"The Army believes the civilian population is willing to make any sacrifices necessary to insure the care of the wounded," OWI quoted Major General Norman Kirk, Army Surgeon-General.

The exigencies of war demand that reserves be on hand for emergencies, for expanded operations, and a preorganization of hospitals against the need to set up such establishments on foreign soil, he said.

On the basis of information from the Army, Navy, and the War Manpower Commissioner's Procurement and Assignment Service, OWI reported commissioning of doctors into the armed reserve is falling behind monthly quotas, despite a lowering of requirements to meet civilian demands.

Adjustments to civilian needs already include deferments granted to commissioned internes to allow civilian hospitals an adequate supply of resident physicians and a reduction of the Army's ratio of doctors to troops from the 8.5 doctors to 1,000 men-regulation set forth shortly after the Spanish-American War.

The changed ratio calls for 53,000 civilian doctors in the Army and Navy, and of these, 46,000 had been commissioned as of August 15, OWI said. The 8.5 ratio was reduced March 18 to 6.6 doctors per 1,000 men in combat and 4.6 doctors per 1,000 in nonbattle areas.

Reporting a trend among doctors to wait to be drafted rather than to enlist because they feel certain they will be commissioned anyway, OWI quoted the Procurement and Assignment Service as describing this as "a dangerous practice."

The Office of War Information said several doctors have gone through basic Army training as privates as a result of such procedure.

"Application for commission on the eve of induction does not necessarily prevent a doctor from being drafted and undergoing basic training as a private in the Army or an apprentice in the Navy," it said. "Regular procedure would call for the doctor to remain in training until his commission is processed. Should he fail to receive it, he would continue on the same basis as untrained inductees."—San Bernardino *Sun*, October 21.

Miracle Men on the Field

The Army and Navy have just announced that they require seven thousand additional doctors by December 31, "to insure even minimum care of the wounded."

How superb is the treatment given our disabled is cleverly demonstrated by these heretofore unprinted facts: Although many of the injured suffer complications from tropical diseases, only 2½ per cent succumb. The World War I's mortality rate was 8 per cent.

Sixty per cent of those maimed on Guadalcanal have been returned to the line of duty. Never before in all military annals were such records made.

As this is Navy week, it is fitting to describe methods used by the seagoing medical fraternity in accomplishing these feats. One is that each devil-dog and gob is taught first aid; immediate attention is imperative.

The captain of the battleship South Dakota collapsed when a steel fragment severed a large vein in his neck, and death was a matter of minutes. A chief quartermaster trained for the emergency—not a physician—stanched the flow of blood and saved the skipper's life.

Fallen United States marines in the Solomons seldom waited even ten minutes before naval corpsmen crawled to their assistance under fire. But medicos and stretcher-bearers had to discard Red Cross brassards and white bandages because Japanese sharpshooters deliberately used these conspicuous badges of mercy as targets.

Pershing's veterans remember the anguish of their comrades, groaning on the soggy ground of the Argonne. Today medical doctors immediately administer morphine to block off shock and pain and to sustain the victim's morale.

In 1918, boys lay for hours—and sometimes days—in the forests and shell holes of no man's land until badly infected. Now instant application of sulfa drugs destroys gas bacillus, the cause of gangrene.

War surgeons assert that blood plasma, donated back home, is the "greatest single contribution to life-saving." A transfusion was given to a dying lad during a jungle cloudburst while doctors used their ponchos to keep off the rain. Later he led his platoon in the battle of Buna.

Those who stopped boche bullets in France and Belgium were taken from the field in ambulances. Every jolt on the shell-pocked road was torture. Many a kid did not live to reach an evacuation hospital. Now a stricken soldier is lifted into an airplane and gently carried miles from the roar and danger of warfare.

The Navy has made ten thousand flights from scenes of action with only one forced landing. In that case the craft came down on a reef in a heavy surf. An ordinary corpsman—the sole professional man aboard—with three cracked ribs tended sixteen patients and brought them back alive.—San Mateo *Times-Leader*, October 27.

Aid for Service Wives

Physicians from seven western states returned home on November 4 following the close of a conference to work out a more suitable plan to aid wives and children of service men.

"Medical practitioners believe the Government is doing the right thing in caring for needy service families, but they also believe intelligent coöperation between the patient, the Government, and the physician will be of greater benefit to all concerned," said Dr. Karl L. Schaupp, President of the California Medical Association, which hosted the meeting.

At present, it was explained, physicians have had no part in the planning and administration of the maternity and pediatrics program for service families. Opposition to the "mandatory and inflexible fee schedule" as set up by the Government was expressed. A certain flexibility is desired, it was said, to depend upon the difficulties of the case.

"For instance," it was pointed out by one of the attending physicians, "a flat fee of $50 has been set by the Government for prenatal, delivery and postpartum care. This does not take into consideration the possibilities of surgery. We feel that a better plan must be worked out on a basis that will satisfy everybody."

Amendment to Agreement Regarding Temporary Hospitalization and Medical Care Necessitated By Enemy Action to Civilians

(COPY)

OFFICE OF CIVILIAN DEFENSE
WASHINGTON 25, D. C.

Circular: General Series No. 12

1. *Payments to Hospitals.* — Under the agreement of above dates, the Public Health Service planned to pay $3.75 per patient day for hospitalization of patients of the Emergency Medical Service in both Casualty Receiving Hospitals and Emergency Base Hospitals. . . . It is hereby agreed that, effective July 1, 1943, the Public Health Service will pay hospitals for the care of patients of the Emergency Medical Service at the per diem rate of $4.25.

2. *Payment for Nurses at Emergency Base Hospitals.*—The original agreement does not include as a federal responsibility payments to nurses at Emergency Base Hospitals. . . .

3. *Payment for Transportation of Patients to Emergency Base Hospitals.*—No provision was made in the original agreement for the use of federal funds to pay for the transportation of patients to Emergency Base Hospitals. In order to expedite such transportation under the stress of enemy action, it is desirable that federal funds be made available to pay such costs. . . .

* * *

Hospital Personnel in Civilian Defense: Circular Defines Status

(COPY)

November 22, 1943

Hospital personnel should be enrolled in the U. S. Citizens Defense Corps or in the Civilian Defense Auxiliary Group according to the duties they are expected to assume during an air raid alert, a new circular from the Medical Division of the Office of Civilian Defense explains (Circular, Medical Series No. 34, "Enrollment of Hospital Personnel in the U. S. Citizens Defense Corps.")

Those who will participate in the care of casualties and who are expected to report and work at hospitals as volunteers will be enrolled in the Medical Unit of the Defense Corps, and Nurses' Aides in the Nurses' Aide Unit, the circular states. Other hospital personnel whose duties are related to maintenance of hospital service or to the protection of services should be trained for and enrolled in the appropriate units, such as air raid wardens, fire guards, communications, emergency welfare, or utility repair. . . .

* * *

California Changes in Staff of the Medical Division Office of Civilian Defense

(COPY)

November 22, 1943

Dr. Courtney M. Smith, assistant regional medical officer in the Ninth Civilian Defense Region, recently stationed in Seattle, Washington, has been promoted to be regional medical officer, with headquarters in San Francisco. He succeeds Dr. Fred T. Foard, senior surgeon, U. S. Public Health Service, who has been made district director, U. S.

Public Health Service District No. 8, with headquarters in Denver. Prior to his appointment in the Medical Division of the Office of Civilian Defense, Doctor Smith was assistant health commissioner of Alaska. He holds the rank of surgeon in the U. S. Public Health Service Reserve. . . .

Medical Journals—For Colleagues in Military Service

In former issues, editorial comment was made on a plan to forward medical journals to the hospital stations of Army, Navy, and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The addresses of the three libraries follow:

University of California Medical Library, the Medical Center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals via "Railway Express Agency," collect, to: California Medical Association Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261). The "Railway Express Agency" will call for packages and will collect costs from the California Medical Association. The Postgraduate Committee will forward to camps.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

MATERNITY-PEDIATRIC PLAN OF FEDERAL CHILDREN'S BUREAU

(Additional items—Continued from pages 79-88, CALIFORNIA AND WESTERN MEDICINE, for July (Items I to XVIII); September, pages 178-182 (Items XIX to XXIII); October, pages 226-231 (Items XXIV to XXX); and November, pages 282-284 (Items XXXI to XXXVII).

For editorial comment in this issue, see page 304.

* * *

ITEM XXXVIII: MATERNITY-PEDIATRIC

Resolution Adopted by the Sonoma County Medical Society

WHEREAS, The Sonoma County Medical Society is not in favor of the present method of payment of doctors in the Emergency Maternity and Infant Care plan, as this interferes with the patient-doctor relationship; and

WHEREAS, It appears that the same procedures for the care of soldiers' wives could be handled by paying the patient directly and the patient arranging with the doctor; and

WHEREAS, The County Medical Society is in accord with the proper care of soldiers' wives in maternity and only objects to the principle of payment; therefore, be it

Resolved, That the Sonoma County Medical Society wishes the Council of the California Medical Association to do everything it can to bring about a change in the payment policy for this service.

ITEM XXXIX: MATERNITY-PEDIATRIC

United States Childbirth Aid Given Ten Thousand West Coast Service Wives

More than four thousand California women, wives of service men, have received medical care through pregnancy and childbirth and aid for their babies through the first year of life. Dr. Edith P. Sappington, western region medical director for the Children's Bureau, U. S. Department of Labor, recently announced in a report on the federal program from April 1 to November 1.

In the eight western states and Alaska, 10,000 cases were helped, and more than 99,000 throughout the nation, the Department disclosed. All but three states in the nation are coöperating with the Government in providing maternity care without cost to wives of servicemen in the fourth, fifth, sixth, and seventh pay grades. Application forms may be obtained from doctors, hospitals, Red Cross chapters, or health agencies.

WAGNER-MURRAY-DINGELL BILL

(S. 1161; H. R. 2861)

Reader: Have you written your Congressman? You will find his name and Washington address in the November issue of "California and Western Medicine," on pages 284 and 285. The time to act is now! As one of your Congressman's constituents, acquaint him with your point of view. Every physician owes this to the welfare of his fellow citizens, his profession, and himself.

What Our Colleagues in Military Services Think About Socialized Medicine: Obligations of Physicians in Civilian Practice

(From Tom Treanor's "Home Front")

Naples.—You people back home have got us all nervous over here. We don't know what you're up to, but we're sure it's no good. If it isn't a G. I. afraid of losing his gal to a war worker, it's a flyer worrying you're going to slip over prohibition again while he's overseas. No more whisky, no more beer.

* * *

And last night it was the doctors, growling about socialized medicine. While they're serving God and country here, they suspect you over there are doing them dirt with some sort of medical social security plan.

Half a dozen surgeons who treat some of our men who fly gathered by candlelight in their gloomy barn-like hospital operating room last night to play bridge and kibitz, but before they got the cards shuffled they'd started brooding out loud on this worrisome subject. Said Capt. Chester R. Lulenski, surgeon, of Cleveland:

"Certain plans to provide maternity and infant care for wives and children of enlisted men have already been put into effect in several States against the recommendations of the respective State medical associations."

* * *

It's not that the medical profession opposes improvement of medical care for everyone.

"But it's not fair that such a bill should be passed while a goodly percentage of the medical profession is overseas unable to speak for or against it."

There wasn't a word of dissent. Captain Lulenski, 30, had the perfect audience for his statement.

Encouraged, Capt. Donald E. Rossiter, 43, of Highland Park, Illinois, declared:

"The least return that can be made to the medical men is that they be allowed to return to what they left behind because that is what we are fighting for."

You'll hear that sentiment all up and down the Army and the Air Force from the humblest private to the handsome colonel. They want to come back to the same America they left behind. No brave new world. They want you people at home to keep hands off their America until they can get back and have their say, too. Who's starting this war, they want to know. And what for? We're fighting it, they say, so America will be the same.

It's a hopeless proposition, but that's what they feel over here.

This is the doctors' day. Let them finish their plea. They make some very good points.

"The social reformers started this," said Lieut. Wilbur E. Davis, Charleston, Missouri, "when the people were very conscious about the inadequate medical care at home. But why is the medical care at home inadequate?"

Major William E. Houston of Palo Alto, California, answered him.

"It's inadequate because the doctors have volunteered in such large numbers to take care of our soldiers, sailors, and marines."

* * *

And then Captain Lulenski returned to the argument. "There are many who will point to the success of Army medicine as an example of the success from state regimented medicine. But they don't mention that the success of Army medicine is based on the skill of thousands and thousands of doctors who until recently were in private practice."

Capt. Jerry J. Belden of Watertown, New York, backed him up.

"It can be specifically stated that in countries of our enemy where national socialized medicine has been practiced, Germany for example, there has been a deterioration of German medicine as compared with ours. Perhaps deterioration is not the word. The other way to express it is that American medicine, under the stimulus of private initiative, has progressed much more rapidly during a similar period."

* * *

Capt. Albert B. Chapla of Lorain, Ohio, put in a word of explanation about different types of Army care.

"There is no doubt but that in battle, when everybody, including the doctors, is worked up to a crisis and it is a matter of life and death, the American soldier gets the best care in the world. But it should not be forgotten that socialized medicine will not be administered under the stimulus of battle conditions. It will be given in routine and will be better compared with garrison treatment of soldiers."

"Yes," said Lieut. Morton Lepler of New York, "the garrison-type medicine more or less epitomizes socialized medicine."

* * *

Then Capt. John Mooney, Jr., of Statesboro, Georgia, concluded the discussion by advocating whole-heartedly that such auxiliary services as x-rays and laboratory analyses, which run patients into high expenditures, be put as quickly as possible on a socialized or insurance basis.

To this all agree, still holding firm that you people back home should keep hands off the medical profession until the doctors can get back and have their say in the drafting of the socialized medicine bill. They mean it.

* * *

For myself, I'm just a stenographer taking notes.—From *The Home Front,* by Tom Treanor.

Social Security for the Business Man Suggested

What the Chief of the Social Security Board Advocates

Chairman Arthur J. Altmeyer of the Social Security Board has suggested including the self-employed—the small business man and the professional group—in the old age and survivors insurance program to give them "a better chance of survival" in the system of free enterprise.

Writing in the Social Security Bulletin, he said this particular group has felt keenly the impact of war and thousands of small business men have been forced to close their doors. He estimated a net loss for this year of 300,000 establishments in the retail field alone.

The independent professional group generally has a higher income than the small business proprietors, he said, but the proportion with low incomes is much greater than commonly realized. More than 10 per cent of the physicians, 13 per cent of the dentists and attorneys, and from 20 to 30 per cent of other professional groups had incomes of less than $1,000 in 1934.

American Bar Association: Resolution In Re: S. 1161 (Wagner Bill)

(COPY)

Resolved, That the Board of Governors be requested to immediately appoint a special committee to study, analyze and investigate Senate Bill 1161 and that the Board of Governors give publicity to the recommendations and findings of such special committee and the action of the Board of Governors taken thereon; be it further

Resolved, That the House of Delegates is opposed to any legislation, decree or mandate that subjects the practice of medicine to federal control or regimentation beyond that presently imposed under the American system of free enterprise.

RE: MIGRATORY AGRICULTURAL WORKERS: THEIR HEALTH CARE

Amendment to Public Law 45

(See in November issue of "California and Western Medicine" for other comments, on pages 256 and 287.)

(COPY)

UNITED STATES SENATE
Subcommittee on Wartime Health and Education

November 9, 1943.

Karl L. Schaupp, M. D., President
California Medical Association
450 Sutter Street, Room 2004
San Francisco 8, California

My dear Doctor Schaupp:

I wish to acknowledge your communication of October 18 concerning an amendment to Public Law 45 providing for adequate medical care and health services for migratory workers not actually recruited and transported under the Federal Migratory Farm Labor Program.

Senator Hiram Johnson of California introduced an amendment to Public Law 45 on October 29, 1943, which will provide for just such medical care as you recommend. The amendment reads:

> *Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That subsection (a) of Section 3 of the joint resolution, entitled "Joint resolution making appropriation to assist in providing a supply and distribution of farm labor for the calendar year 1943," approved April 29, 1943, as amended, is amended by striking out the word "and" before the figure "5" in the last sentence in such subsection; and by striking out the period at the end of such sentence and inserting in lieu thereof a semicolon and following: "and (6) furnishing, by loans or otherwise, of health and medical services to migratory workers, engaged in agricultural work, and to members of the families of such workers, to whom adequate health and medical services are not otherwise available in the area where they are employed, whether or not such workers have been recruited or transported pursuant to this joint resolution."

This amendment has been referred to the Senate Committee on Appropriations. Be assured that I will give the amendment my whole-hearted support.

Sincerely yours,

(Signed) CLAUDE PEPPER, *Chairman,*
Subcommittee on Wartime Health and Education.

November 17, 1943.

Dear Doctor Kress:

I shall be more than glad to support legislation such as that introduced by Senator Johnson which would make possible the carrying on of the very excellent health and medical service to migratory workers which has been made possible through the coöperation of the California Medical Association and the Farm Security Administration in the past.

As a matter of fact, Congressman George Outland has introduced an identical bill to Senator Johnson's in the House and I have already assured Mr. Outland that I will be glad to do anything within my power to help secure its passage.

Sincerely yours,

(Signed) Jerry Voorhis,
[Twelfth District, California.]

* * *

November 18, 1943.

Dear Doctor Schaupp:

Your letter of October 18, in reference to a proposed amendment to Section 3(a)2 of Public Law 45, Seventy-Eighth Congress, concerning medical care of agricultural workers, has been received.

I referred your communication to the Appropriations Committee, which is now holding hearings on the supplemental estimate of the appropriation for the Department of Agriculture in the amount of $35,000,000 for the Farm Labor Supply Program, in accordance with House Document 345, copy of which I herewith enclose. I call your attention to the marked portion, which embodies the amendment in which you are interested.

It is expected that hearings will be concluded by the Committee some time this week.

Sincerely yours,

(Signed) Clarence F. Lea,
[First District, California.]

* * *

November 11, 1943.

Dear Doctor Kress:

In the absence of Mr. Engle, who is in California at the present time making an official investigation of the recent rioting at the Japanese camp at Tule Lake, I am acknowledging receipt of your letter of November 9, 1943, together with a copy of S. 1493 introduced by Senator Hiram Johnson.

I can assure you of Mr. Engle's continuing interest in the migratory agricultural workers and will place your communication on his desk for his attention upon his return to Washington.

Very sincerely yours,

(Signed) Clair Engle,
[Second District, California.]
By Jack Matteson,
Secretary to Mr. Engle.

* * *

November 15, 1943.

Dear Doctor Kress: S. 1493

Your letter of November 9 regarding S. 1493 has been received.

It is a pleasure to collaborate with Senator Johnson, and I am introducing a companion bill in the House.

As soon as copies are available I shall send same to you and in the meantime, with every good wish, I am

Cordially,

(Signed) Thomas Rolph,
[Fourth District, California.]

* * *

November 13, 1943.

Dear Doctor Kress:

I have received your letter of November 9 with reference to an amendment to Public Law 45 relative to migratory agricultural workers.

Congressman Outland has introduced the bill in the House, and I have assured him of my full coöperation.

Very sincerely,

(Signed) Richard J. Welch,
[Fifth District, California.]

* * *

(copy)

American Medical Association
535 North Dearborn Street
Chicago 10, November 16, 1943.

My dear Doctor Kress:

Please accept my thanks for your kindness in sending me a copy of your letter of November 11 addressed to Doctor Schaupp, a copy of a communication signed by Doctor Schaupp and by you addressed to the members of Congress from California, and a copy of a measure introduced by Senator Johnson proposing to amend a joint resolution making an appropriation to assist in providing a supply and distribution of farm labor for the calendar year 1943.

I have noted especially that in the measure submitted to the Senate by Mr. Johnson, provision is made for furnishing, by loans or otherwise, of health and medical services to migratory workers engaged in agricultural work, and to members of the families of such workers.

I am referring your letter and the enclosed material to our Council on Medical Service and Public Relations.

Very sincerely yours,

(Signed) Olin West, M. D.,
Secretary and General Manager.

New Federal Law Streamlines United States Health Service

On November 12, President Roosevelt signed into law legislation streamlining the Public Health Service, providing for temporary promotions in rank for some of its officers and making allowances and benefits similar to those for the armed forces available to them.

Under the new law the service will be reorganized into three divisions, operating under the Surgeon-General. These divisions are the National Institute of Health, responsible for research; the Bureau of Medical Services, which will operate all hospitals and clinics; and the Bureau of State Services, to administer grants to the states.

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

Relocation of Physicians

The United States Public Health Service is having a tough time persuading the Senate to appropriate $1,000,000 for the relocation of doctors to areas where medical services are desperately short. Senator Kenneth McKellar of Tennessee, chairman of a Senate Appropriations Subcommittee considering the bill, left no doubts about his position during a recent closed-door hearing.

When Senator Claude Pepper of Florida was attempting to explain how the $1,000,000 was to be used in placing six hundred physicians and dentists in areas where there was an extreme shortage, Senator Rufus Holman of Oregon broke in:

"Will the Senator tell me if the matter of socialized medicine enters into this at all?"

Senator Pepper replied that there were apt to be epidemics in certain sections unless the Federal Government stepped in. He quoted letters and telegrams from Dr. James Paullin of Atlanta, Georgia, president of the American Medical Association; Surgeon-General Norman T. Kirk of the Army; and Dr. Frank Lahey of the War Manpower Commission's Procurement and Assignment Service, endorsing the proposed appropriation.

Shortage of Nurses Acute

War Manpower Chief Paul V. McNutt on November 24 stated the shortage of nurses on the fighting and home fronts may become so acute as to interfere with the war program.

His appraisal was contained in an announcement of a nation-wide registration of all graduate nurses to be conducted in the second week of February as a move toward mobilizing nurses for wartime needs.

San Francisco County Medical Observes Its Seventy-Fifth Anniversary: Announcement From Its "Bulletin"

Culminating three-quarters of a century of continuous medical service to the community, the San Francisco County Medical Society on Sunday, November 7, will celebrate its diamond jubilee. War-time conditions prevent elaborate observance of this important anniversary, but the Society, in honor of the occasion, will present a symposium on "The Future of Medicine," preceded by several days of special clinics at local medical schools.

The first attempt to form a medical society in San Francisco occurred in 1850 in the early days of the gold rush. This pioneer group dissolved within a few months, but other societies were organized in 1851, 1853, and 1855. By 1865 all of these had disappeared because of rapidly shifting population in the young city, internal disputes, and the impact of the Civil War, many of the local doctors in early days having been Southerners.

In 1868 the San Francisco County Medical Society was reorganized with fifty members and has been in continuous existence ever since. At the present time it has 1,187 members, of whom 1,116 are in active practice or on war leave. Growing with the city and changing its home many times, the Society in 1926 acquired and has since occupied as its headquarters the beautiful Irwin mansion, surrounded by extensive grounds, on Laguna Street between Washington and Jackson streets. This fine three-story building houses the Society's offices, meeting rooms, and the Irwin Memorial Blood Bank.

Throughout its seventy-five years the Society, naturally, has devoted the bulk of its energies to the task for which its members have been trained—caring for the welfare of residents of the community. However, through the years from the time when a trip by horse and buggy into the sand dunes in the westerly part of the city to attend a patient was a real adventure, down to the present time when transportation once more is restricted to essentials, the Society has kept its members abreast of the latest advances in medical knowledge by weekly and semi-monthly meetings, at which leading physicians reported on new discoveries and techniques. Through its Committee on Professional Conduct it has exercised a beneficial discipline within the ranks of the profession. In general, it has played an active rôle in placing San Francisco in the forefront of American cities, not only as a medical center, but with respect to general improvement in the public health and the decrease of infant mortality.

The County Medical Society has not, however, been merely an association of medical men and women for their mutual benefit and protection. It has also directly interested itself in many projects broadly affecting the community health. One of these was the San Francisco Milk Commission.

MILK COMMISSION

Aroused by the prevalence in San Francisco of childhood tuberculosis, typhoid fever, and scarlet fever—all directly traceable to impure milk—the County Medical Society, in 1908, instituted the first milk commission in the West.

It established rigid standards of sanitation and inspection, and certified dairies meeting its specifications. This certified milk was sold for a little above the price of uncertified milk. The movement gradually spread to the entire Bay area, and to Sacramento, Vallejo, San Jose, and Suisun. In 1933, the Society coöperated in securing passage of a municipal ordinance requiring that all milk sold in the city must be pasteurized.

These measures combined to decrease infant mortality in San Francisco from 190 per 1,000 live births in 1907 to 31 per 1,000 in 1940—a direct result, as City Health Director J. C. Geiger has pointed out, of the activities of the Milk Commission.

Finally, the Commission's campaign had raised milk standards in the Bay area to a point where the group had worked itself out of a job. In 1941, with all the larger dairies producing milk up to the Society's specifications, whether officially certified or not, the Commission considered its work accomplished, and disbanded.

IRWIN MEMORIAL BLOOD BANK

Alert to the lifegiving possibilities of blood transfusions and transfusions of blood plasma, the Society, in 1941, established one of the first "blood banks" in the United States and the only one in the country to be owned and operated by a county medical society. The establishment of the Irwin Memorial Blood Bank by the Society antedated by a considerable period the attack at Pearl Harbor, and the Society was thus in a position at the outbreak of the war to render outstanding service to the armed forces and to civilian defense organizations in this area, while the American Red Cross was getting its forces mobilized to take over this outstanding job.

With the Red Cross assuming charge of collecting blood and plasma for the armed forces, the Irwin Memorial Blood Bank now confines its services to its original purpose of providing lifegiving blood and plasma for civilian casualties and, to a limited extent, for our Allies of the United Nations.

A modern laboratory, equipped with the latest in blood freezing and drying apparatus, centrifuges and sterilizers, has been installed on the lower floor of the County Medical Society's headquarters. Here, at all hours of the day and night, blood of every type and classification is available on instant notice for delivery to any hospital in San Francisco or the Bay region. Because whole blood has proved superior to plasma when it is possible to give it, the bank maintains in its refrigerator a supply of all types of whole blood.

After ten days, blood not used in whole form is converted into plasma and stored for emergency use in disaster—earthquake, fire, air raid or other emergency. Through the medium of the Irwin Memorial Blood Bank, every hospital in San Francisco has been furnished an emergency supply of blood plasma for use in the event of air raids.

Since the blood bank opened, it has had 23,765 donors; 13,406 units of whole blood have been sent to hospitals.

A small service charge covers the incidental expenses connected with the bank's operation.

MUNICIPAL EMPLOYEES' HEALTH SERVICE SYSTEM

Although group health insurance had not entirely won the approval of the medical profession at large, the County Medical Society early recognized that such health protection was socially desirable. Accordingly, the Society coöperated with the 10,000 employees of the municipal government in organizing, in 1938, the Municipal Employees' Health Service System, whereby the employees might, for a small monthly fee deducted from their pay checks, protect themselves and dependents against future medical and hospital needs.

The Society fought for and won the principle of "free choice of physician" in the charter amendment creating the system, and that principle in the system prevails today.

During the five years since the founding of the system, there have been much give and take, many ups and downs, but the system at the present time is operating on a fairly even keel, is financially sound, and is paying the doctors of the Society and others who serve the system full value for their services. However, during the life of the system, the Society contributed approximately $400,000 in unremunerated services in order to bring it through its formative period.

At the present time the Society has the satisfaction of knowing that its sacrifice of time, money, and effort, collaborating with municipal employees in this endeavor, has resulted in what many consider one of the model group health insurance systems in the nation.

CALIFORNIA'S PHYSICIANS' SERVICE

Another activity along this line is the California Physicians' Service, a health insurance program operated by all the physicians of California themselves.

The San Francisco society was one of the strongest advocates of this system when it was launched in 1938 and has strongly supported it ever since. The wisdom of the California Medical Association in establishing and operating this system has been thoroughly vindicated since Pearl Harbor, as the service has been the only means found to supply medical service to the mushroom cities and housing developments which have sprung up around war-industry cities, besides taking care of thousands of individuals in other walks of life.

Without California Physicians' Service, solution of the medical problems of these huge areas, and of the State at large, would have been far more difficult than it has been.

WAR SERVICE

About one-third of the County Medical Society's members now are on active military or naval service, and more stand ready to go when called. Whether a physician goes or stays now, however, is not much a matter of personal wish as it is of obeying orders, since the service of medical men on the war front or on the home front is governed by the procurement and assignment service of the Federal Government, which designates which doctors are essential to maintaining the health of the civilian community and which doctors may be spared for the armed forces.

San Francisco may be proud of the number and caliber of its medical men who have taken their places with our soldiers and sailors. Three of the Society's members have already made the supreme sacrifice on active service.

Throughout the entire operation of Selective Service the members of the Society, in common with their colleagues elsewhere in the nation, have examined selectees, entirely without compensation. Every San Franciscan selected to go to war thus has first passed the keen eyes of a San Francisco physician reporting on his physical condition to his draft board.

COUNTY SOCIETIES[†]

CHANGES IN MEMBERSHIP

New Members (25)

Alameda County (4)

Fisher, Lloyd D., *Albany*
Kuh, Clifford, *Oakland*
May, Eugene Samuel, *Oakland*
Splithoff, Clarence A., *New York City, N. Y.*

Marin County (1)

Didier, F. W., *Mill Valley*

Orange County (1)

Ostich, Nathan H., *Anaheim*

Riverside County (1)

Mead, Franklin B., *Riverside*

Sacramento County (3)

Chamberlin, Herbert E., *Sacramento*
Engelberg, Dalton J., *Sacramento*
Long, John B., *Sacramento*

San Diego County (4)

Davies, Thomas F., *San Diego*
Green, Dwight M., *Vista*
Monsees, Wayne E., *San Diego*
Rowland, Alan L., *San Diego*

San Francisco County (8)

Chester, Spencer T., *San Francisco*
Clark, Wallace Dayton, *San Francisco*
Orr, Dorothy Ruth, *San Francisco*
Pearson, Claude Woodring, *San Francisco*
Richli, Elmira Mary, *San Francisco*
Rossen, Allan Morris, *San Francisco*
Thomas, Sydney F., *San Francisco*
Robin, John E., Jr., *San Francisco*

Santa Barbara County (1)

Foster, William S., *Santa Barbara*

Santa Clara County (1)

Bethel, R. D., *Oakland*

Ventura County (1)

Anderson, Ruth, *Ventura*

Transfers (1)

Rutherford, Miriam H., from San Francisco County to Alameda County.

Resignations (1)

Slepnikoff, Steven F., San Francisco County.

In Memoriam

Bartle, Ira Bennett. Died at San Luis Obispo, November 7, 1943, age 72. Graduate of Tulane University of Louisiana School of Medicine, New Orleans, 1901. Licensed in California in 1920. Doctor Bartle was a member of the San Luis Obispo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

[†] For roster of officers of component county medical societies, see page 4 in front advertising section.

Buchanan, Robert Ambrose. Died at Lodi, October 25, 1943, age 77. Graduate of California Eclectic Medical College, Los Angeles, 1896. Licensed in California in 1896. Doctor Buchanan was a retired member of the San Joaquin County Medical Society and the California Medical Association.

* * *

(Note.—"In Memoriam" and Obituary records that do not appear in this number will appear in the next issue of California and Western Medicine.)

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (October, 1943)		51,550
Rural Health Program		5,000
War Housing Projects (approximate)		31,120
Marin	5,861	
Los Angeles	6,752	
Alameda	1,700	
Vallejo	14,788	
San Francisco	2,019	
Total		87,670

From time to time we have received a number of comments from professional members on the administrative costs of the California Physicians' Service operation. Most of these communications question the high percentage of administrative costs.

Almost without exception, medical service plans have experienced high administrative costs during their formative years, and it seems quite probable that this condition will continue until a large volume of membership is attained on a fixed and continuous policy. This is the natural outcome of operations in a field in which many mistakes have already been made, and where there is no assurance that other mistakes will not be made in the future.

In such an unknown field as that of prepaid medical care, an organization must necessarily gear itself to the unexpected. Personnel must be trained completely in the complications involved in this business, and must also be prepared to accept increasing amounts of business. The organization must be able to absorb new enrollments without adding new personnel at that point, and, in order to accomplish this purpose, personnel must be employed and trained before the new enrollment is attained.

The two largest items of cost in California Physicians' Service administration are the salaries of its general staff personnel, and the costs of its acquisition functions. In the past year there has been an increase of approximately 70 per cent in the costs of salaried personnel, and an increase of approximately 130 per cent in the costs of acquisition. These increases are representative of additional persons employed and higher salary levels paid.

The number of persons employed, except for acquisition, is related to the maintenance of functions respecting the membership already enrolled. In 1942 we employed one person in the general office for each 1,300 beneficiary members covered. In 1943 the number of beneficiaries covered has increased, but the number of administrative persons is only one to each 1,400 beneficiaries. The general level of salaries in all business has increased materially in the past year. The salary levels paid in California Physicians' Service are not as high as those paid generally for the same type of work. For instance, two years ago California Physicians' Service was employing junior office clerks at a beginning salary of $85 per month. We are now paying a beginning salary of $110 per month for the same type of work. However, throughout the Bay area of San Francisco, the general scale for such people is $125 per month. This same principle applies to practically all of the types of employees necessary in our operation.

Acquisition costs have increased generally for the same reasons. We have a greater number of persons employed in acquisition functions, and higher salaries are being paid. Basically, the acquisition of new members is the life blood of any such organization as California Physicians' Service. Without continual additions of new memberships, our membership would dwindle to a level which would not support the necessary administrative staff. During the past year, enrollments of new groups have been made at an increased rate over previous years. However, cancellations of memberships, caused by the extremely high turnover in employment, have made the actual net gain in memberships relatively small. In order to effect a net gain of 1,000 persons, it has been necessary to enroll 2,000 to 3,000 persons. This condition not only inflates acquisition costs, but also causes an additional amount of work for the office staff in accounting, collection, and record-keeping. In other words, it is just as costly to put a new member on our lists who only stays a month or two as it is to put a permanent member on our lists.

The measurement of administrative costs in terms of percentage is sometimes misleading. For instance, in September of 1942 administrative costs were 23½ per cent of income. In September of 1943 administrative costs were 24 per cent of income. However, there are 50,000 persons covered now, as against 38,000 a year ago. In 1942 the cost per member covered was 31½ cent per month. This year it is only 28¼ cent per member per month.

California Physicians' Service, because of its experimental nature, has been compelled to develop and maintain a system of statistical information from which we can study costs and other operation problems in this unknown field of prepaid medicine. Without this information, we would have been unable to make certain of the improvements already made, and we would be without information to guide us on future improvements. Nevertheless, these functions require personnel and time, and are an important factor in the total administrative cost.

The fundamental difference between the kind of program California Physicians' Service is operating and other static businesses is the need to gear our organization for expected increases in volume in the future. If we could be assured that a given number of persons covered would remain with us from month to month, without the necessity of acquiring new business, the administrative costs would drop immediately to approximately 15 per cent. However, if we had no acquisition of new membership and the present rate of cancellation was experienced, the actual administrative costs could not be reduced as rapidly as membership income would fall, and there would be a corresponding rise in the percentage of administrative costs. There is no exact parallel with which to compare California Physicians' Service operations. The nearest would be the City Health Service of San Francisco, which has a static membership, but does not have to pay the expenses of acquisition, collection, or accounting that California Physicians' Service operation requires. Their administrative costs naturally should be considerably lower than California Physicians' Service.

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† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone, EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Meetings will convene in Los Angeles. Dates of the seventy-third annual session, to be held in 1944, Sunday, Monday, May 7-8.

American Medical Association. Sessions will be held in Chicago (not St. Louis) on June 12-16, 1944. (See *The Journal of the American Medical Association*, November 6, 1943, page 644.)

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday program at 10:15 a. m., under the title "Your Doctor and You."

In December, KFAC will present these broadcasts on the dates of December 4, 11, and 18.

The Saturday broadcasts of KFI are given at 9:45 a. m., under the title "The Road of Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association, in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy, are on the air each Saturday at 2 p. m., Pacific War Time. Series will commence on January 8, 1944. Will run for twenty-six weeks.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Provocative:* E. G. Conklin's *Man: Real and Ideal* (Scribner's, New York, 1943) offers challenging observations and reflections on man's nature, development, and destiny, scientifically sound and artistically offered. H. E. Sigerist discusses the University's dilemma (*Bull. Hist. Med.*, 14:1, 1943) in facing the dangers to research. How about the danger of a scientific canon developed through control of the scientific journals by prejudiced editors?

2. *Psychiatry:* W. A. Bryan discusses *Administrative Psychiatry* (Norton, New York, 1943). A. Deutsch presents a history of the *Mentally Ill in America* (Doubleday, New York, 1943). Not as good as G. Zilboorg's *History of Medical Psychology* (Norton, New York, 1941) is J. K. Winkler's *Mind Explorers* (Reynal, New York, 1943). S. S. Tompkins edits a reprint collection on *Contemporary Psychopathology* (Harvard, 1943). Harvard also publishes S. Cobb's excellent *Borderlands of Psychiatry*. O. S. English and G. H. J. Pearson discuss *Common Neuroses of Children and Adults* (Norton, New York, 1943). H. R. Love offers an excellent summary on dyspeptic symptoms in soldiers (*Med. Jour. Australia*, 2:101, Aug. 7, 1943), showing that appropriate man management may reduce symptoms in two-thirds.

3. *Historical:* M. F. A. Montagu discusses Edward Tyson (1650-1708) and the rise of human anatomy in England (*Mem. Amer. Philo. Soc.*, 20:1-476, 1943). Interesting series of discussions on the early history of science and learning in America is sponsored by the American Philosophical Society (*Proc.*, 81:1, 87:1, 1943). The Society also offers its bit on postwar problems (*Proc.*, 87:2, 1943). L. T. Morton revises F. H. Garrison's *Medical Bibliography* (Grafton, London, 1943), with the usual omission of recent significant work. Oleanders (Galveston orchids) to Dr. and Mrs. F. A. Hitchcock for their translation of P. Bert's *Barometric Pressure: Researches in Experimental Physiology* (College Book Company, Columbus, Ohio, 1943).

4. *Antibiotics:* E. Chain, H. W. Florey & Co. gives an excellent report on helvolic acid derived from culture filtrates of aspergillus fumigatus (*Brit. Jour. Exp. Path.*, 24:108, 1943), with chemical work suggesting the possibility of synthesis of related compounds may be not too complex. Squibb offers a penicillin bibliography and set of abstracts. Squibb's Medical Journal Abstracts are a worthy printed continuance of the successful mimeographed series of long ago.

5. *Etc.:* H. Hurst discusses permeability and molecular constitution as factors in drug action (*Nature*, 152:292, Sept. 11, 1943). Vale to H. G. Barbour, productive to the end: He made excellent study on water shifts in deep hypothermia (*Amer. Jour. Physiol.*, 140:9, 1943). O. R. Klimmer offers a useful discussion of poisoning from combustion gases (*Arch. Exp. Path. Pharmakol.*, 201:69, 1943). N. G. Yu and Y. Y. Ying state that sternal puncture and the ephedrine provocative test are very helpful in diagnosing chronic malaria (*Chinese Med. Jour.*, 61:31, 1943). J. J. Izquierdo offers an excellent discussion of the importance of mathematics in physiology (*Gac. Med. Mexico*, 73:280, 1943). N. E. Maver and M. K. Barrett show

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† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

caphepsin difference between tumor and normal tissue (*Jour. Nat. Cancer,* 4:65, 1943).

American Medical Association Scientific Exhibit: Palmer House, Chicago, June 12 to 16, 1944.—The Scientific Exhibit at the Chicago session of the American Medical Association, June 12 to 16, 1944, will be held at the Palmer House. Exhibits will cover all phases of medicine and the medical sciences, with particular emphasis on graduate medical instruction for the physician in general practice.

Application blanks for space in the Scientific Exhibit are now available and may be obtained by communicating with the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago, 10, Ill.

Nurses Adopt Standard Fee Schedule.—A schedule of standard fees, to be charged everywhere in California, regardless of previously existing scales in various localities, was voted by the private duty section of the California State Nurses' Association recently at its convention in San Francisco.

The state-wide group, winding up its annual conference at the Fairmont Hotel, meanwhile elected Miss Edna B. Behrens, formerly of San Francisco's Franklin Hospital and now director of nursing at the Sonoma County College of Nursing, to serve its 13,000 members as president during the coming year.

The new fee scale for private duty nursing will be at the rate of $8 for a standard eight-hour day shift, with the same charge for more than four hours but less than eight, and an additional $1 for each hour of overtime. The scale from 11 p. m. to 7 a. m. or for any part of that period will be $8. Scale for a similar period spent caring for alcoholics, violent mental cases or patients with communicable diseases will be $9.

In action designed more fully to utilize the supply of private duty nurses, the group voted that one nurse may undertake the care of two patients, who will split the regular fee, with an additional $1.50 to $2 premium for an eight-hour shift. The group also voted to engage as "fully as possible" in staff replacement programs, as the hospitals where they are employed in private duty may need them.

Lung Taken Out in Field Operation.—Major Paul Samson, a well-known Oakland chest surgeon, recently performed, successfully, under adverse field conditions in Algiers, one of the most delicate operations ever attempted in such surroundings—complete removal of a man's lung, according to an Associated Press release recently.

The patient was a German soldier, so badly wounded by shell fragments in the chest that one lung had to be removed to save his life.

The Allied Headquarters surgeon's office said the patient now is alive and well.

"Although already performed many times in the United States and Britain," the surgeon's office said, "a total pneumonectomy under field and emergency conditions in a station hospital is a banner story for the annals of battlefield medicine."

University of California Electron Microscope Installed.—An electron microscope capable of magnifying objects up to 13,000 times has been installed at the University of California, and scientists at the Berkeley institution now are using the device.

The instrument is similar in principle to an ordinary microscope except that it substitutes electron beams for light and magnetic fields or electron lenses for optical lenses. The electron beams pass through a vacuum and are focused by the magnetic fields, it was explained.

The specimen to be examined is placed on a thin, plastic film within the vacuum and the electrons stream through, making a shadow on a fluorescent screen or photographic plate. The photographs taken on the machine may be enlarged 100,000 times compared with 2,000 times for those taken on the microscope using light beams, according to Dr. Charles W. Porter, chairman of the School's Committee on Research.

Doctor Ratio in San Francisco: 1 to 600.—San Francisco's medical needs are well taken care of—one physician to 600 persons—despite the fact that some 500 San Francisco doctors have entered the armed forces, it was announced recently by Dr. Harold A. Fletcher, State Chairman of the Procurement and Assignment Service.

San Francisco's ratio of doctors to civilians remains well above the national proportion, but more doctors under forty-five here will have to enter military service.

Of the Society's total membership, nearly one-third are in the service. Three of its members have been killed—Comdr. Eric Liljencrantz and Navy Lieutenants Allen A. Altman and Charles A. Rethers.

Dr. George Thomason Elected President of the California State Board of Medical Examiners.—Dr. George Thomason, head of the Department of General Surgery of the College of Medical Evangelists, at a meeting of the California State Board of Medical Examiners, October 18 to 21, was elected president of the Board. Doctor Thomason is now serving his sixth year as a member of the Board, having been appointed first by Governor Rolph in 1938. He was reappointed by Governor Olson in 1940.

Barlow Society for the History on Medicine.—Dr. Esther Rosencrantz, associate professor emeritus, University of California, delivered an address on the subject of "Sir William Osler" on November 18 before a combined meeting of the Los Angeles County Medical Association and the Barlow Society for the History on Medicine. Many rare items from the Osler collection in the Crummer Library of the University of California Medical School were combined with items from the Los Angeles Medical Library to make a large and interesting Osler collection, which was available at the meeting for the inspection of the audience. Dr. George Dock, who was one of Doctor Osler's colleagues during the Pennsylvania period, added a recital of a journey made with the great physician in search of rare books. Doctor Rosencrantz was a member of one of the last classes taught at Johns Hopkins by Osler.

Speakers on Narcotic Enforcement.—The Division of Narcotic Enforcement of the Department of Penology of the State of California, with offices at 156 State Building, San Francisco, of which F. J. O'Ferrall is chief, has presented addresses through its representatives at the San Francisco County Medical Society, the University of California Medical School, Stanford University School of Medicine, and College of Medical Evangelists. The talks aimed to acquaint members of the profession with the many phases of work coming under the supervision of the California Division of Narcotic Enforcement. Program committees of county societies can obtain further information by writing to Chief F. J. O'Ferrall.

The American Otorhinologic Society.—This society was formed for the advancement of plastic and reconstructive surgery, and held its first annual meeting on November 12, in the New York Academy of Medicine.

A prerequisite for membership in this organization is that the applicant shall be a specialist with diplomate recognition. One of its primary purposes is to effect an increase of facilities for reconstructive surgery, both through training to increase the skills of professional men generally, and through extending hospital accommodations. Demands for reconstructive surgery will be augmented after the war.

The Society aims to foster opportunities for surgeons generally, outside its membership, to increase their knowledge and skill to meet needs which are already becoming apparent.

Additional information may be secured from the secretary, Dr. Jacob Daley, 104 East Fortieth Street, New York 16, N. Y.

United States Aid Sought for Laboratory.—Renovation of Building No. 20 at the General Hospital at a cost of $175,000 and its equipment as a laboratory and classroom for medical students may be made possible by a contribution of that amount from the Federal Works Administration, it was disclosed yesterday.

A. J. Will, County Superintendent of Charities, has requested permission from the Board of Supervisors to apply for the money needed, pointing out that the laboratory and classroom are needed. Will said that the building, if renovated and equipped, will be leased to the University of Southern California for the use of first and second-year medical students for a token fee.

At the close of the emergency, Will said, the building would revert to county service fully renovated and equipped.—Los Angeles *Times*, November 28.

Heart Disease Toll to Mount.—Medical science believes that for the first time it is coming to grips with rheumatic fever on something like even terms.

But heart diseases—rheumatic fever, high blood pressure and hardening of the arteries are the commonest and deadliest types—still constitute the nation's No. 1 killer and will increase in coming years.

These conclusions were reported on November 4 by Dr. Tinsley R. Harrison, heart specialist of Winston-Salem, North Carolina, in San Francisco as guest speaker at the fourteenth annual postgraduate symposium on heart disease. The symposium was sponsored by the Heart Committee of the San Francisco Tuberculosis Association.

Lecturing at Stanford Hospital, Doctor Harrison presented the novel argument that there can be too much rest in some cases of heart disease.

"I believe rest is like any other treatment," he said. "You can overdo it. I know that most men in our field disagree with me."

One of his reasons for believing that rest can be "abused," he said, is that constant inactivity can tend to produce a querulous psychotic.

Reporting on rheumatic fever, which accounts for most cases of heart disease in persons under forty, Doctor Harrison said:

"Just in the past few years there has developed evidence that certain drugs of the sulfa and salicylate groups, used immediately after discovery of throat infection, are effective."

Since heart disease is, in most cases, an affliction of those past fifty, heart disease can be expected to increase as man's normal span of years is increased, the specialist said.

"And we're not going to make much progress against it until we know the causes of the heart disease," he added.

Doctor Harrison presented the view that liquor in small quantities does no harm to the patient with heart disease.

"What little evidence there is on the subject indicates that slight drinking would be more beneficial than harmful," he said. He defined slight drinking as drinking so light that there is no evidence of intoxication and no interference with eating habits.

LETTERS[†]

Concerning Consent to Operation Upon Married Women Under Twenty-One Years of Age:

(COPY)

San Francisco, November 24, 1943.

My dear Doctors:

We have been asked what consent should be obtained before performing medical or surgical operations upon married women under the age of twenty-one years, particularly those whose husbands are absent in military service.

California Civil Code, Section 204, provides that the authority of a parent ceases upon a Court appointment of a guardian of a child, upon the child's marriage, or upon its attaining majority. In view of this section, the consent of the parents of a girl under the age of twenty-one years is not sufficient to adequately protect a physician if the girl is married.

Civil Code, Section 25, provides that minors are all persons under twenty-one years of age, provided that any girl of the age of eighteen or over who has contracted a lawful marriage is deemed to be of the age of majority and an adult person for the purpose of entering into any transaction. Under this section the consent of the girl eighteen years of age or over, who is married and upon whom the operation is to be performed, is sufficient.

If the girl is less than eighteen years of age and is married, the consent of her husband should be obtained before any operation is performed upon her. If he is absent in military service, making it impossible to obtain his consent, in our opinion you should not perform any services other than emergency, in which event consent is presumed.

If you have any further questions, please let us know.

Very truly yours,

HARTLEY F. PEART.

Concerning Recent Articles in "California and Western Medicine":

NATIONAL PHYSICIANS' COMMITTEE FOR THE EXTENSION OF MEDICAL SERVICE
A Nonpolitical, Nonprofit Organization for Maintaining Ethical and Scientific Standards and Extending Medical Service to All the People
The Pittsfield Building, Chicago, Illinois

November 11, 1943.

To the Editor:—This will acknowledge receipt of and express appreciation for your valued letter of November 1 and the receipt of the August and October issues of CALIFORNIA AND WESTERN MEDICINE.

May I congratulate you. The handling of the de Kruif opus is unusually good; comment on the Wagner-Murray Bill 1161 is clear-cut, concise, and effective. Thank you, Doctor Kress, for the kind references to N. P. C.

There can be no question but that we are moving forward to a point of final settlement. If we can maintain interest and sustain efforts that have been initiated, there can be little doubt as to the defeat of S. 1161, but more important, the prospect of permanently influencing the trend toward state control of medical service.

With the best of personal good wishes,

Sincerely yours,

NATIONAL PHYSICIANS' COMMITTEE FOR E. M. S.
(Signed) John M. Pratt,
Executive Administrator.

[†] CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Prevention of Malpractice Actions

During the present emergency when the number of patients cared for by most physicians has increased considerably, great care should be taken by all physicians and surgeons to avoid malpractice claims and actions. In this connection, the book "Medical Malpractice," written by a member of the California Medical Association, Louis J. Regan, M.D., LL.B., published this year, contains an exceedingly helpful discussion of the importance of the physician's office nurse in the prevention of malpractice claims. Every physician would be well advised to consider carefully the suggestions made in Doctor Regan's book.

In Chapter XII, page 164, Doctor Regan presents the following discussion:

> To protect himself from a legitimate accusation of malpractice, the physician must care for every patient with meticulous attention to the requirements of good medical practice; and he should endeavor, in so far as possible, to be in a position to prove that he has done so in every case. His greatest aid in this respect is the medical case record. This should show what was done and when it was done, and should contain a recording of instructions given the patient, the written history, the physical examination, the reports of laboratory examinations, and the progress record. A good medical case record should make clearly manifest that the case was conducted with the requisite degree of care and skill. The record should also show, if such is the case, that the patient failed to carry out instructions or discontinued treatment prematurely; a good method of establishing this fact is to file a carbon copy of a letter sent the patient, advising against the unwise course. The record cannot be considered complete in any case of real or suspected bone or joint injury, unless it contains a very complete x-ray record of the case. In the event that the patient is subjected to any unusually hazardous treatment, such as fever therapy or shock therapy, the record should also contain a statement signed by the patient, expressing understanding of the nature of the special treatment and consenting to undergo it. Another fact to remember, in order to avoid later difficulty, is that, because of the possibility of error in transmission, it is dangerous to telephone a prescription.
>
> It is obvious that, for the most part, malpractice claims arise out of cases with bad end-results. When a patient has a less than perfect result and is dissatisfied, the situation calls for the exercise of the greatest tact on the part of the physician and his office assistant. For example, the irritation of such a patient by unwise collection efforts may result in the filing of a malpractice action. The friendly patient, the patient who feels that everything that can be done is being done, is not likely to sue his physician. In some cases the calling in of a consultant will serve to restore a more satisfied attitude in a patient who is becoming critical. In all circumstances a consultant affords great protection against a malpractice claim. It is an excellent plan to have a consultant see every patient who is not doing well, and every patient who is complaining of his treatment or expressing dissatisfaction with the progress he is making. The tactful handling of a patient, if it may not be considered an essential and actual part of the medical treatment itself, is at any rate second in importance only to the actual therapy of the case. It is of great importance to the well-being of the patient, and it is exceedingly important in safeguarding the physician against a malpractice claim. Oftentimes the handling of the patient and the patient's family by the office nurse spells the difference between suit and no suit against the physician.

The Time Is Now!

What Must Be Done If the Medical Profession Is to Fulfill Its Fundamental Obligation to the American People?—A Plain Call to Action!

The time has come . . . for plain speech, for bold thinking, and for decisive action. Bureaucratic control of medicine in starkest form, with all its obscene implications for the future of medical art and science, is an imminent probability.

Let it now be clearly emphasized that in opposing the injection of political control into the administration of medical service, doctors do not imply any complacent toleration of the *status quo*. The record on that is clear. No other profession or calling has more radically and continuously improved the content and methods of its service than medicine, during the past half century.

Yet, through its ostrich-like policy of inept public relations, the medical profession has permitted itself, during the past fifteen years, to be portrayed to the American people as a selfish vested interest, stubbornly opposing every suggestion or effort by social-minded people to improve the distribution or to reduce the costs of medical care.

Our failure clearly to interpret ourselves, our accomplishments, and our sincere purpose to the American people has rendered the art and science of American medicine exquisitely vulnerable to political manipulation by a bureaucracy seeking new ways of perpetuating its power. Furthermore, Medicine's position of responsibility to the public places it at the mercy of political attack or envelopment.

What *can* be done, . . . what *must* be done, if we are to fulfill our fundamental obligation to the American people, and our responsibility to those who will follow us in our profession?

First, we *can*, even at this eleventh hour, *frankly and honestly tell our own story*, utilizing *in our own name* all the available means and media of modern public relations. If the American Medical Association must forfeit its tax-exempt status for the privilege of interpreting, not itself, but the medical profession to the American people (an assertion which we don't believe and hereby challenge)—then by all means let us buy our chips and get into the game! *Is it more important to the welfare of the American people for us to be exempt from taxes than from bureaucratic dictation?*

Second, we *can*, even at this eleventh hour, *establish an information and service bureau in Washington*, openly dedicated to the need of maintaining a continuous two-way channel of intercommunication between the medical profession and the people, the federal agencies, and legislators who are interested in the services we render. The need for a Washington office for the American Medical Association is so obvious and urgent as to make any further delay in its establishment a matter of criminal negligence, in our opinion.

Third, we *can*, even at this eleventh hour, *assume our earned and rightful place of leadership* in the councils of those who seek to mould the future of our calling. We must certainly expect great and fundamental social changes; we will probably have to accept an increasing degree of proper governmental participation in medical service. But in any case the profession must assert and maintain a definite status in the formulation of all legislation on health and medical matters. Merely to confer with governmental agencies cannot reasonably be construed as evidence that medicine has accepted their theories or philosophies concerning medical service. On the contrary, medicine owes it to the public, as it surely owes it to its own members, to assert its earned leadership in determining its own future. *The time is now!**

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† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

* The article opposite appeared in the *Westchester Medical Bulletin*, published by the Medical Society of the County of Westchester, in its November, 1943, *Bulletin*. For editorial reference thereto, see page 303.

* For other reference, see footnote in adjacent column.

TWENTY-FIVE YEARS AGO[†]

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 12, December, 1918

EXCERPTS FROM EDITORIAL NOTES

1919 Annual Meeting.—The Committee on Scientific Program is working on the 1919 meeting of the State Medical Society. The problems of rehabilitation and peace, together with the return of many members from the military, will make this session of universal interest and importance. It is needless to say that the attendance will be large. Preparation of a program that shall be worthy these stirring and strategic times is an onerous task. . . .

Shell Shock.—The term shell shock is a misnomer and should be abolished, according to an article on the nature of war nervousness in soldiers in "War Medicine," published by the American Red Cross, and the simple word, "nervousness," substituted.

Under the heading of shell shock, says the author, have been massed cases of amnesia, anergic stupor, sleeplessness, nightmare, mutism, functional blindness, tremors, palsies, and further anxiety neuroses, occurring, not only under fighting strain but in individuals who, failing in self confidence, suffer doubts and apprehensions while still waiting for transport overseas.

The term shell shock founded on false premises has served not only to suggest an incorrect etiology, but by its pitiful and romantic sound, has tended to perpetuate symptoms and to excite no determination in the mind of the sufferer to recover his control, or, in the fighting man still to endure. So far is it from making an appeal to conscience or to discipline, that it stifles both, and stultifies effort towards cure. The name is a mistake. We must be rid of it. Let us have instead a true term which will be neither a compromise nor a technicality unintelligible to the mind of the soldier. . . .

Department of Industrial Medicine.—Beginning next month with the issue for January, 1919, the JOURNAL will institute a Department of Industrial Medicine. The reasons for this department are as definite as the functions it will endeavor to subserve.

Physicians have learned many lessons from their military experience. They have learned discipline and organization. This lesson will be speedily taken to heart in the approaching development of group diagnosis and treatment. The future organization of the profession will be compact and closely related to governmental insurance problems, industrial needs and a better understanding of public health needs. Doctors must organize as they have never organized before, or their economic independence will cease.

Physicians have learned many lessons in preventive medicine. The enormous impetus to industrial development in the era ahead, together with the large recognition of the responsibility of the public and the employer for the worker and his health, will force the physician to exercise an intelligent interest in industrial medicine. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Intracranial Complications of Diseases of the Ear, Nose and Throat.—A Report of Some Unusual Cases with Autopsy Findings," by Hill Hastings, M. D., Los Angeles, Calif.—Intracranial complications that

(Continued in Front Advertising Section, on Page 16)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA[†]

By F. N. SCATENA, M. D.
Secretary-Treasurer

Board Proceedings

A written examination, in addition to those previously scheduled, was held in San Francisco on November 16, 17, and 18, 1943. This additional examination was held in conformance with the rule of the Board to hold frequent examinations, both written and oral, to assist in licensing qualified doctors at as early a date as possible after application.

An oral examination was held on November 18, 1943, at the Board office in San Francisco.

News

"Dr. F. R. DeLappe of Modesto today was succeeded on the State Board of Medical Examiners by Dr. Herbert S. Chapman of Stockton. The appointment was made by Governor Warren. Doctor DeLappe had served continuously on the Board since 1931, when he was appointed by the late Governor James Rolph, and was president most of the time. Doctor Chapman is president of the staff of Dameron Hospital in Stockton, a Fellow of the American College of Surgeons, and a member of the Pacific Coast Surgical Association. His term will expire in January, 1947. . . ." (Modesto *Bee*, October 19, 1943.)

"The State Board of Medical Examiners today had announced seventy-five persons were successful in examinations for physicians and surgeons, held in Los Angeles on August 10, 11, and 12. Eighty-one persons took the examination and a passing percentage of 75 was required, Dr. Frederick N. Scatena, secretary of the Board, said. The highest mark, 91 per cent, was scored by Isaac Murphy Berry, Los Angeles, a graduate of the College of Medical Evangelists. . . ." (Los Angeles *Daily News*, October 18, 1943.)

"Resumption of the emergency maternity and infant care program was announced last night by Dr. Wilton L. Halverson, director of the State Department of Public Health. Government paid maternity care for wives of service men and medical care for their sick infants is available under the program, which started in July and is now operating in thirty-five counties, including Humboldt. Suspended on September 15, due to lack of funds, resumption is possible with telegraphic information from the United States Children's Bureau that funds are available immediately from a new congressional appropriation of $18,600,000. . . ." (Eureka *Times*, October 2, 1943.)

"In spite of shortage of medical facilities in many places, the picture of civilian health in the United States is generally good, according to data from the United States Public Health Service, the War Manpower Commission, and the Federal Works Agency. In 1942, the death rate was the lowest on record, 10.3 per thousand; the birth rate had risen to 20.7 from 18.7 per thousand in 1941, and the maternal mortality rate dropped for the thirteenth consecutive year. To compensate for the shortage of doctors in certain areas, the Public Health Service and the War Manpower Commission are taking many steps, such as seek-

(Continued in Back Advertising Section, on Page 26)

[†] This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

[†] The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

In the "Chronic Fatigue" of Mild Depression

After employing Benzedrine Sulfate therapy in a series of 40 patients diagnosed as suffering from nervous exhaustion, Nathanson concludes:

"In approximately 80 percent of the patients there was a marked amelioration of this symptom (fatigue). Many of the patients had complained of fatigue for long periods and had tried various types of treatment without benefit . . .

"A sense of increased energy and capacity for work was noted in more than half of the cases. In addition a feeling of exhilaration and sense of well being was a consistent effect . . . Many patients volunteered that there had been a definite increase in mental activity and efficiency." Nathanson, M. H.—J. A. M. A., 108:528, 1937.

Benzedrine Sulfate Tablets

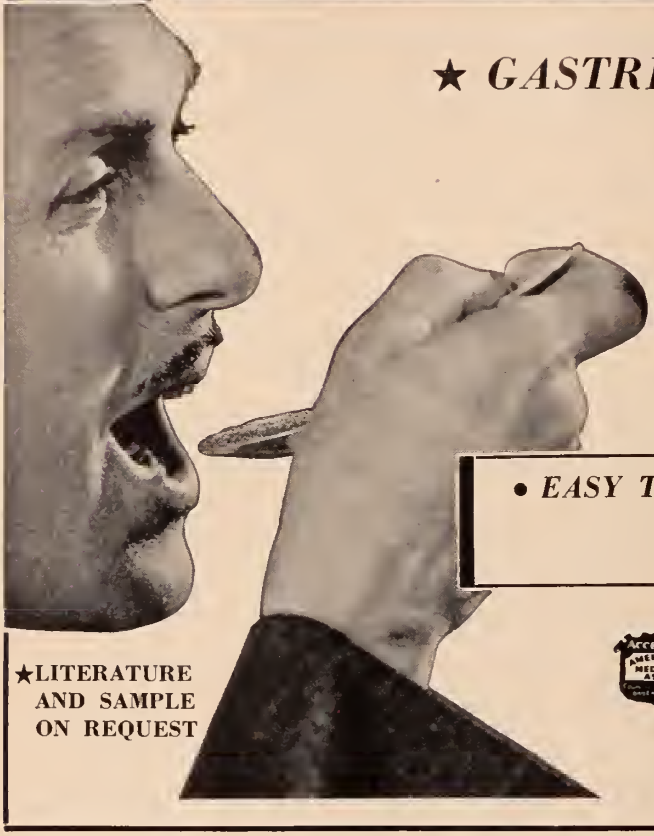
Brand of racemic amphetamine sulfate

Benzedrine Sulfate is primarily useful in depressions characterized by apathy and psychomotor retardation, but is contraindicated in patients manifesting anxiety, hyperexcitability, or restlessness.

The use of Benzedrine Sulfate by normals should not be permitted; it should always be administered under the careful supervision of a physician; and depressive psychopathic cases should be institutionalized.

In treating depressed patients with Benzedrine Sulfate, the physician should bear in mind that any drug which produces pleasant or euphoric effects may prove to be habit forming—especially in unstable or neurotic individuals.

SMITH, KLINE & FRENCH LABORATORIES
PHILADELPHIA, PA.



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869 Folsom St. . . SAN FRANCISCO, CALIF.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 352)

ing to shift doctors to shortage areas, limiting recruitment for armed services to twenty states and the District of Columbia, which are relatively well supplied; helping local authorities organize coöperative use of medical facilities, and improving and increasing hospital and clinical facilities. . . ." (Fall River Mills *Tidings*, September 24, 1943.)

"On an inspection tour of the Desert Training Center the first of this week, three important Army officials visited Headquarters Communications Zone. They were Major General Norman Thomas Kirk, Surgeon-General of the United States Army, Colonel Raymond W. Bliss, chief of operation and training of the surgeon-general office, and Col. William B. Shambors, surgeon of the Army Ground Forces. The General and his party were accompanied on their inspection tour of Communications Zone medical installations by Lt. Col. Harold A. Furlong, surgeon for the Communications Zone. . . ." (Banning *Record*, September 30, 1943.)

Los Angeles Area Jumps to Third in Population

War Population Shifts Place Metropolitan District Ahead of Philadelphia and Detroit

Wartime migrations of population have made Los Angeles the third largest metropolitan area in the country. It surpasses Philadelphia and Detroit and is exceeded only by the metropolitan areas of New York and Chicago. The Census Bureau recently estimated the metropolitan area, comprising Los Angeles and Orange counties, at 3,105,503 civilians as of last March 1.

This is a jump of 191,745 since the census total of 2,913,758 on April 2, 1940. It is a 6.6 per cent increase.

The comparisons are not by city boundaries but by metropolitan areas which extend beyond city limits.

Computation for Area

The Census Bureau gave no breakdown on the basis of particular counties or cities. The estimates were computed from registrations for War Ration Book No. 2, and it is believed many persons living in one county may have signed up in another in the same metropolitan area.

New York, with 11,087,990 persons in its metropolitan area which extends into northeastern New Jersey, and Chicago, with 4,542,579, still lead the nation in size. However, both these areas have declined since 1940 because of wartime population shifts, the New York area losing 436,028 and Chicago 32,113.

Philadelphia's metropolitan area population was set at 2,973,730, a gain of 20,606, and Detroit's at 2,554,301, a gain of 180,478.

Washington, D. C., led the nation's cities in metropolitan area growth since 1940, being up 261,715 to a new total of 1,181,347. San Francisco Bay was second, with the combined population of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Solano counties up 254,279. Los Angeles was third in the three-year increase. San Diego ranked near the leaders in civilian increases with a population of 379,719 now as compared with 276,079 in its metropolitan area in 1940.

The increase for the nation approximated 1,690,000, or

(Continued on Page 28)

Rapid and pronounced reduction of stomach acidity

Creamalin promptly reduces stomach acidity. Moreover, the antacid effect is sustained.

With Creamalin there is no compensatory reaction by the gastric mucosa and no oversecretion of hydrochloric acid. Furthermore, there is no risk of producing alkalosis.

When employed with an ulcer regimen, Creamalin often induces unusually rapid healing of peptic ulcer.

Supplied in 8 oz., 12 oz. and 1 pint bottles

8 FL. OZ.
CREAMALIN
BRAND OF ALUMINUM HYDROXIDE GEL
SHAKE BOTTLE WELL
KEEP FROM FREEZING
WINTHROP CHEMICAL COMPANY, INC

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Reg. U. S. Pat. Off.
ALUMINUM HYDROXIDE GEL
Non-Alkaline Antacid Therapy

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Pharmaceuticals of merit for the physician
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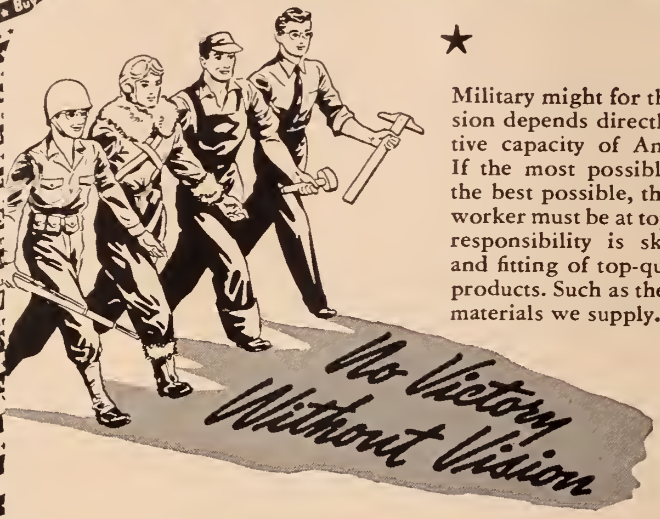

★

Military might for the foes of aggression depends directly on the productive capacity of American industry. If the most possible is to be done the best possible, the vision of every worker must be at top efficiency. Your responsibility is skillful refraction, and fitting of top-quality ophthalmic products. Such as the Bausch & Lomb materials we supply.

RIGGS OPTICAL COMPANY
distributors of BAUSCH & LOMB products

Buy War Bonds

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For Nervous Disorders
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Class "A" buildings affording every modern facility. Located in the quiet country 12 miles east of Long Beach. Classification of patients according to type of illness. Beautiful quiet gardens. Properly equipped for all types of shock therapy. For particulars address: Garden Grove Sanitarium, Garden Grove, Calif.

RICHARD A. CARTER, M.D.
Clinical Director

●

Resident Medical Staff

Los Angeles Area Jumps to Third in Population

(Continued from Page 26)

2.5 per cent, and embraced 137 areas which comprise most of the country's metropolitan centers.

Urban Areas Gain

Of the nation's estimated 128,231,363 civilians, 68,467,329 were placed in urban or suburban areas. This figure of 53.4 per cent represents a rise of 2.5 per cent from the April 1, 1940, estimate.

On a percentage basis Mobile, Alabama, metropolitan area's 53.4 per cent jump from 141,515 to 217,072 was the biggest, while Sioux City, Iowa, suffered the greatest percentage loss, 28.9 per cent, from 103,627 to 73,636.—Los Angeles *Times,* August 25.

Tetanus Immunization of Military Personnel.—All military personnel on induction are being immunized against tetanus either, as in the Army, by three injections of fluid toxoid, or, as in the Navy and Marine Corps, by two injections of alum precipitated toxoid (New Eng. J. Med., 227:162, 1942). In addition, a small or stimulating dose is injected prior to departure for a theatre of operations and an emergency dose is given to those wounded or burned in battle or incurring other wounds likely to be contaminated with *Clostridium tetani.* According to recent report (Am. J. Pub. Health, 33:53, 1943) since June, 1941, when the present tetanus immunization program was adopted, there have been but four cases reported from the entire Army, and none of these were in immunized individuals. Although perhaps too early in the present war to draw any conclu-

(Continued on Page 30)

a Poor Scholar . . . because of a Poor Breakfast

MANY a child is scolded for dullness when he should be treated for undernourishment. In hundreds of homes a "continental" breakfast of a roll and coffee is the rule. If, day after day, a child breaks the night's fast of twelve hours on this scant fare, — or less — small wonder that he is listless, nervous, or stupid at school.

Pablum offers a happy solution to the problem of the school-child's breakfast. Mothers who learn about Pablum from their physicians are delighted to serve it, for it needs no cooking and can be prepared in a minute at the table — more quickly than many less nourishing foods. Right now, this feature is especially valuable in homes where the mother is engaged in war work. Pablum not only ends the bane of long cooking of cereals but in addition furnishes a variety of minerals (calcium, phosphorus, and iron) and the vitamin B complex. It is an excellent vehicle for milk.

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Tetanus Immunization of Military Personnel

(Continued from Page 28)

sions, it is of particular interest that no cases of tetanus have been reported from battle casualties.

For civilian use, especially in children, it is of decided advantage to accomplish simultaneous immunization against tetanus and diphtheria. Combined Diphtheria Toxoid-Tetanus Toxid, Alum Precipitated, Lilly, is designed for prophylaxis only, affords effective immunity against both diseases, and avoids risk of serum sensitization which may follow use of an antitoxin.

Federal Security Agency—National "Rehabilitation Advisory Council"

Appointment of a national Rehabilitation Advisory Council was announced recently by Federal Security Administrator Paul V. McNutt. The new Council, made up of twenty outstanding leaders in training for the handicapped, will, he stated, advise the Office of Vocational Rehabilitation, recently established in the Federal Security Agency, in connection with the expanded Federal-State program of rehabilitation for the handicapped. Administrator McNutt pointed out that, as a war-time measure, an additional concern is to enable handicapped men and women to work in war industry.

Approximately a million and a half persons may be eligible for rehabilitation under the program, according to an estimate presented to the Advisory Council at its first meeting, held on Friday, October 8. Rehabilitation programs to which the Federal Government makes grants are already in operation in all the States, Hawaii, Alaska, and Puerto Rico; it is anticipated that participation in the expanded program will be equally nation-wide.

In opening Friday's meeting of the Council, Mr. McNutt stressed the importance of developing more effective means of meeting the needs of the physically handicapped, and in particular of building up a good program for physical restoration in cases of remediable defects.

"This is a decided expansion as far as federal support is concerned, and in most States will represent a substantial change in emphasis," he said. "The program should go far toward helping the handicapped to become self-supporting—taxpayers instead of tax consumers—and to prepare themselves for taking part in the nation's war effort."

The Council discussed basic plans, policies and regulations implementing the new program. These proposals were presented by Michael J. Shortley, Director of the Office of Vocational Rehabilitation, and John A. Kratz, Associate Director.

The current expansion in this field is the result of the Barden-LaFollette Act, passed in July. This law, which substantially strengthens and extends earlier legislation, provides federal aid to state-administered vocational rehabilitation programs for remedial treatment of physical handicaps, as well as for job training. The federal contribution to states with approved plans covers state administrative expenses for the program; the entire cost of rehabilitation in the case of certain war disabled civilians, and half the cost for other persons. State Boards of Vocational Education are designated as the agencies for the administration, supervision and control of state programs for vocational rehabilitation, with the exception that administration of rehabilitation for the adult blind is committed to State Blind Commissions or similar agencies where such bodies have the necessary authority under state law.

This program for the rehabilitation of civilians serves to round out federal provisions for the handicapped, pro-

(Continued on Page 32)

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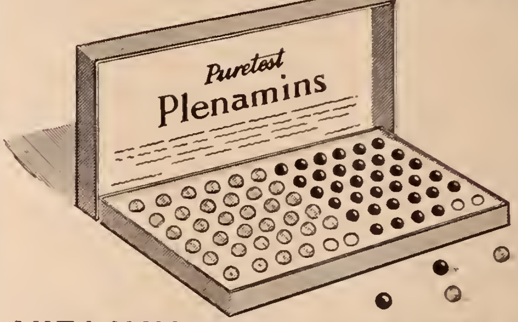

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Federal Security Agency

(Continued from Page 30)

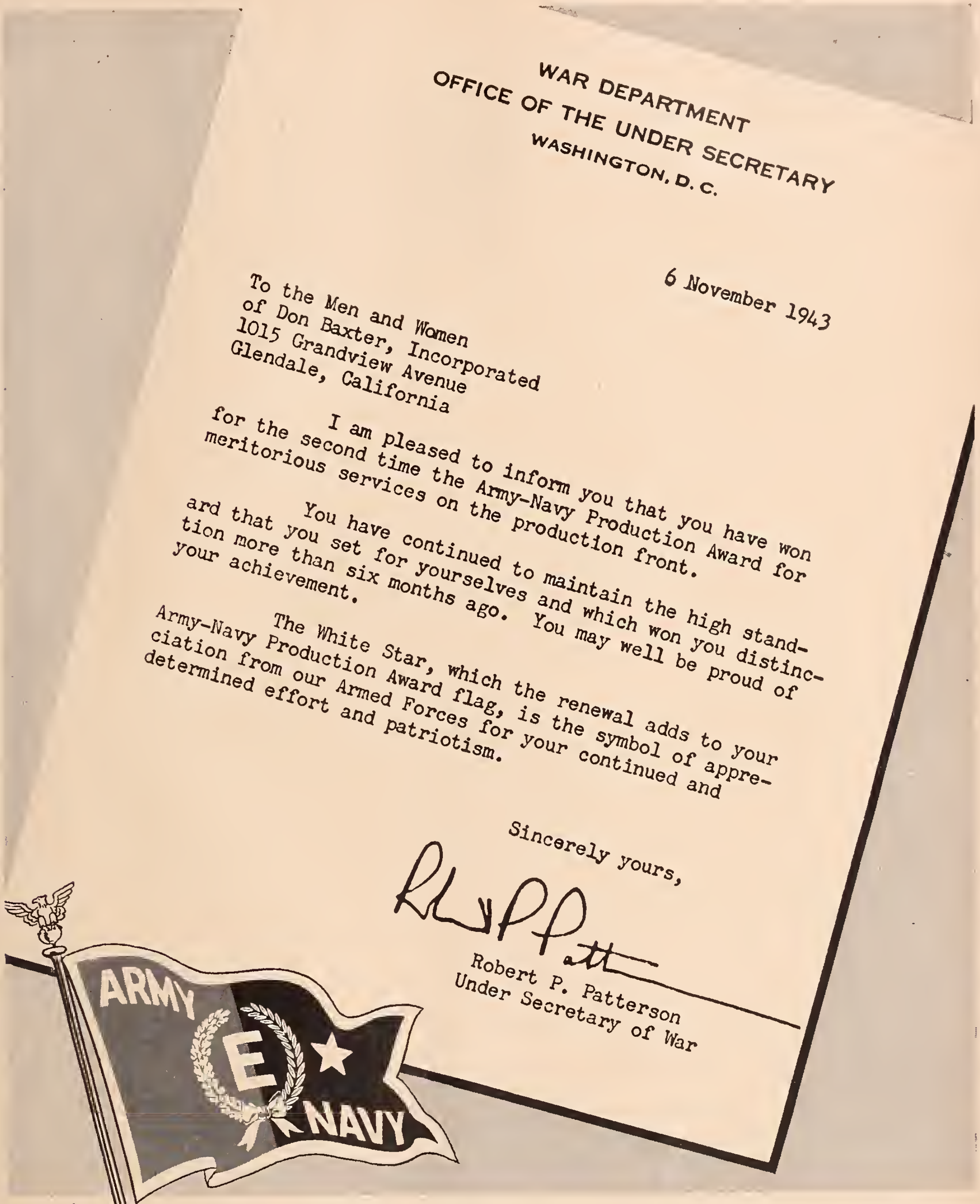
viding care for those not included in the Veterans' Administration program, recently authorized by Congress, for vocational rehabilitation at federal expense for discharged veterans of the present war who have service-connected handicaps.

Members of the Rehabilitation Advisory Council include representatives of various fields—corrective surgery, physiotherapy, occupational therapy, psychiatry, guidance and welfare agencies, education, labor, management—State Directors of Vocational Rehabilitation, and agencies concerned with such conditions as blindness, tuberculosis, and hearing defects.

The name of Miss Catherine Worthingham, President, American Association of Physiotherapy, Leland Stanford University, Palo Alto, California, appears in the list of members of the Advisory Council.

Amebiasis.—The incidence of amebiasis has been shown to be greater than was formerly supposed, and there is reason to believe that the disease may become even more prevalent when large numbers of troops begin to return home from the tropics. Surveys collected before the war revealed that more than one in ten subjects harbored *E. histolytica*. It would seem reasonable, therefore, that whenever intestinal symptoms form a part of the clinical picture, the diagnosis should not be considered complete until the possibility of amebiasis has been ruled out. Chronic, uncomplicated intestinal amebiasis is the most frequent type, and it includes the carrier as well as the individual with recurrent or mildly persistent symptoms.

(Continued on Page 36)



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Amebiasis

(Continued from Page 32)

Pulvules Carbarsone, Lilly, each containing 0.25 gram, may be given orally at the rate of one pulvule two or three times daily to a total of twenty doses (5 grams). This routine may ordinarily be repeated several times, provided intervals of ten days are allowed between courses and the urine and liver show no evidence of damage. Bed rest is not necessary in this group.

United States Venereal Cases Go Up 1.5 Per One Thousand

Increase Due Primarily to New "Uncovering Program"

The officially reported number of venereal disease cases among civilians increased 1.5 per 1,000 in the past two years, but a United States Public Health Service official has stated it was believed this was due primarily to an "uncovering program" rather than a let-down in morals.

Number of cases reported in 1941 was 5.2 per 1,000 population. In 1942 it rose to 5.3 and the indicated rate for 1943 is 6.7, the Public Health Service reported recently.

Not all venereal disease cases get into the records. But examinations for military service as well as for civilian war jobs are believed to have brought to light a larger percentage of cases in the past two years than hitherto.

State health departments listed 487,000 cases of syphilis in 1940 and 590,000 in 1943, while gonorrhea cases increased from 180,000 to 282,000 during the same period.

Most of these cases, it was pointed out, were found among men 18 to 35 years of age, examined for Selective

(Continued on Page 38)

Bequest Forms: Unto the Physicians' Benevolence Fund of the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $——— for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association.

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FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association. a nonprofit corporation of California, the sum of $———, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be paid to and become a part of the Physicians' Benevolence Fund of the California Medical Association as said fund is established and maintained by said Association.

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FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I hereby give and bequeath unto the Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be expended by said corporation for the benefit and as a part of the Physicians' Benevolence Fund of the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California, for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association the following described real property situate in the county of ——— State of California, and more particularly described as follows, to-wit:

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FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be held as a part of the Physicians' Benevolence Fund of the California Medical Association, the income whereof shall be used for the purposes of said fund as it is established and maintained by the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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* Correspondence for the Physicians' Benevolence Committee may be addressed to the C. M. A. office or to Axcel E. Anderson, Chairman, 1759 Fulton Street, Fresno.

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U. S. Venereal Cases Go Up 1 5 Per One Thousand

(Continued from Page 36)

Service. Out of approximately 10,000,000 men examined, 700,000 had a venereal disease.

Army records reveal that of 2,870,000 men rejected through last April 30, a total of 315,700 had venereal disease. The Army since October 1, 1942, has been accepting men with uncomplicated gonorrhea, and since December of 1942 it commenced inducting men with syphilis.

On the other side of the picture, the National Probation Association reported a 16.6 per cent rise in juvenile delinquency in 1942 over 1940. In some areas the increase was as high as 40 per cent and in one community, 70 per cent.

A public health consultant reported that in 162 areas investigated, girls as young as 12 and 13 years were infected, and that in some areas of New York State infected 'teen-age girls outnumbered older girls by four to one.

The Federal Bureau of Investigation reported the percentage of girls under twenty-one arrested for prostitution and commercialized vice increased 64.8 per cent in 1942 over 1941, and arrests for other offenses jumped 104.7 per cent during the same period.

Overall arrests of boys under twenty-one decreased 3.6 per cent in the 1941-42 period, but arrests for sex offenses increased, assault by 17.1 and rape by 10.6 per cent.

Monograph on Lymphogranuloma Venereum.—Noteworthy contributions to the detection and differential diagnosis of lymphogranuloma venereum are those of Rake, McKee and Shaffer, who have cultivated the agent in the yolk sac of the embryonated chicken's egg and obtained concentrated suspensions of elementary bodies. In this manner a highly purified and specific antigen, known as Lygranum S. T., has been prepared which is rapidly supplanting antigens prepared from either human pus or mouse brain. In the course of investigations involving these tests, there accumulated at the Squibb Institute for Medical Research a considerable mass of information concerning the properties of the causative agent, the epidemiology and clinical aspects of the disease. To facilitate the work of investigators and teachers in this field, and perhaps to encourage the interest of potential investigators, practicing physicians, and health officers, it was decided to compile and publish the information at hand. The result is a 32-page publication, entitled "Lymphogranuloma Venereum—A Monograph." The value of the book is enhanced by maps, charts, and numerous illustrations in color.

The Monograph is available gratis to physicians and to public health officials, and will be a valuable addition to medical college libraries. Those who request copies should enclose their professional card or use their professional letterhead.

Address: E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, N. Y.

Absenteeism

To the Editor: There is at present a great deal of justified comment on the widespread problem of absenteeism in war industry. A number of clear studies have demonstrated that the question is not simple and demands an attack from many different sides, a very important one being the rejuvenation of the workers' sense of pride and responsibility.

There is, however, one phase of this inquiry, relatively small yet important, which is generally overlooked and

(Continued on Page 40)

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Absenteeism

(Continued on Page 38)

which can be handled, in large measure, by the family physician. Briefly stated, the real contribution he can make is to take a just, firm stand on requests for "certification."

These requests fall roughly into three types, which I will describe in the order of their importance:

Request for leave of absence because of illness: The generous family physician too often recommends long holidays for minor disorders. . . . It is not only unpleasant, but, for various reasons, also quite imprudent to contradict the family physician; yet this often has to be done. In this emergency it is the function of every physician to see to it that healthy workers are kept on the job as regularly as is humanly possible.

Request for change of shift, the second source of trouble: Most people do not care to work at night. They will think of every conceivable medical excuse and ask the busy family doctor to certify it. . . .

Request for change of job, the last common trouble maker: It is astounding to note how readily the family doctor certifies that certain fumes, gases, vapors, or dusts (about which the patient is poorly informed) are "dangerous" and "poisonous" to the patient, who must immediately be removed to another safer job. . . .

My plea is simply this: Let there be more coöperation between the local and the plant physician. With more consultations there will be fewer conflicts and more man-hours saved.

ANDREW M. BABEY, M. D., Brooklyn.
Chief Medical Examiner, Sperry Gyroscope Company, Inc.
—*Philadelphia Medicine,* June 19, 1943.

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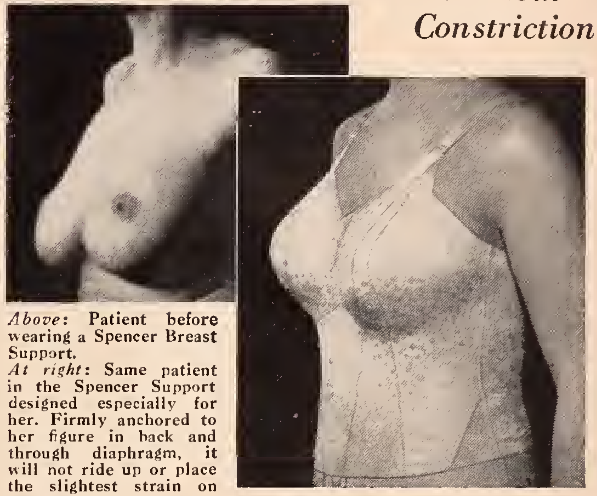

Above: Patient before wearing a Spencer Breast Support.
At right: Same patient in the Spencer Support designed especially for her. Firmly anchored to her figure in back and through diaphragm, it will not ride up or place the slightest strain on shoulder straps!

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Friction of Paralysis Groups Flares Anew

Long-standing friction between the National Foundation for Infantile Paralysis—the "March of Dimes" organization—and its Los Angeles chapter flared into the open yesterday.

As a result, it was announced the local chapter may separate from the National Foundation and set up an independent group.

The disclosure came after an executive meeting of the local chapter at the Biltmore yesterday, at which officers, headed by Dr. Harlan Shoemaker, chairman, and James G. Woolley, executive secretary, were reëlected. Shoemaker and Woolley have been the storm centers of controversy with the national group, headed by National President Basil O'Connor, dating back several years.

Dispute on Policies

Policy matters, as well as financial arrangements, have caused trouble.

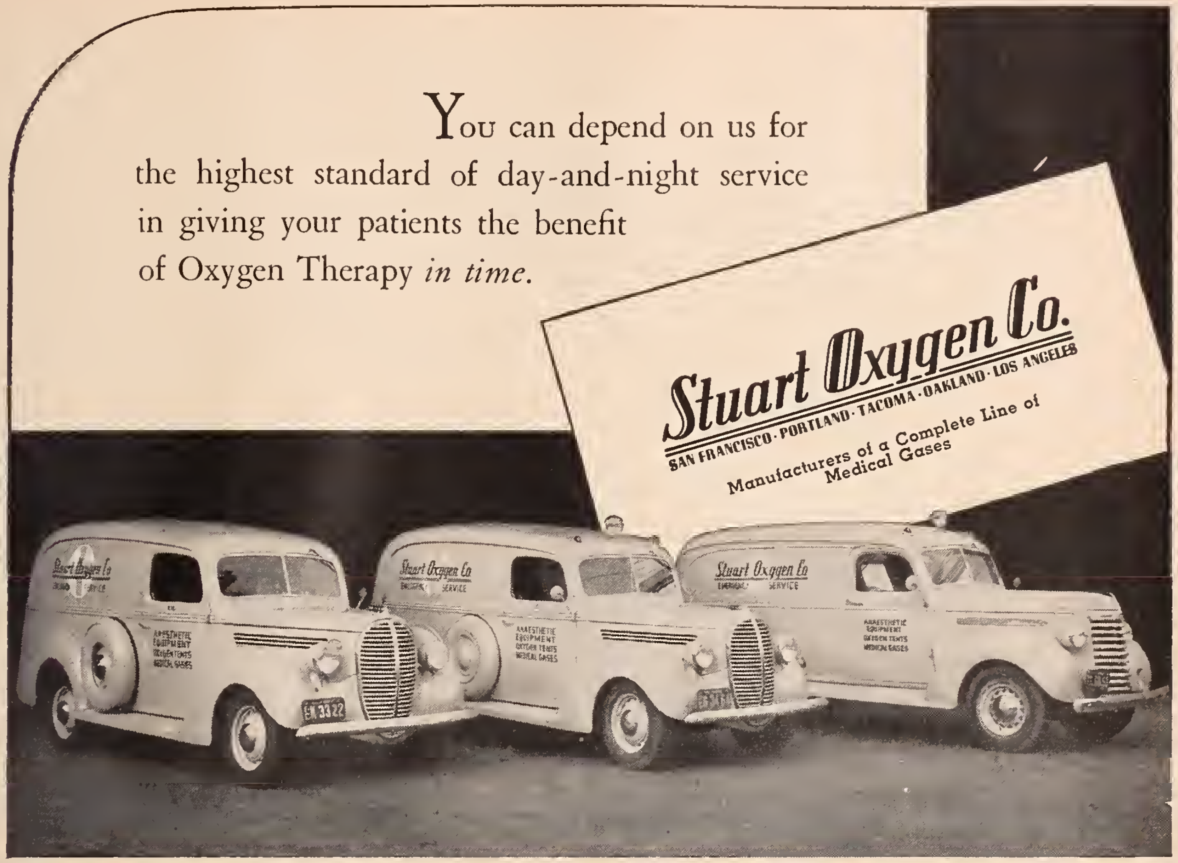
In July, 1941, O'Connor, a former law partner of President Roosevelt, protested the issuance here of a pamphlet by Woolley, the local chapter's paid secretary, on the asserted relationship between electrical equipment and outbreaks of infantile paralysis. O'Connor wired Doctor Shoemaker at that time: "I am amazed that you would permit the Los Angeles chapter to issue this document and that you would use the name of the National Foundation in connection therewith. The work is alleged to be a piece of research and . . . 'a meticulous epidemiological study,' in neither of which any chapter has a right to indulge, as recent communications from your own chapter acknowledge." He ordered that the National Foundation's name not be used further in connection with the pamphlet.

Action Defended

Doctor Shoemaker replied: "I still consider Woolley's observations sufficiently significant to be called to the attention of scientists capable of developing whatever value they may have for combating infantile paralysis and possibly other diseases. . . ."

Several of the largest local institutions treating infantile paralysis cases now have no dealings with the local chapter. . . .—Los Angeles *Times,* October 1.

A Seventeenth Century Tribute to Surgeons.—The following poem, written by Richard Banister of England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prior to 1626, is of interest as it is still a true statement of the public's variable opinion of the surgical profession:

A SURGEON DIVIDED INTO FOURE PARTS: OR THE SURGEON'S COMMENT

A Surgeon's like a God whom they adore:
When death about the sicke man's bed doth sore,
Then hath he great respect, and high regard,
Fed with the smoaky promises of reward.

But as the Patient doth begin to mend,
So doth the Surgeons God-head straightwayes end:
Yet such attendance on him still is given,
As if he were an Angel come from Heaven.

When health and strength the Patients doth inspire,
To sleepe, eate, walke, and sit up by the fire:
Then straight the Surgeons state Angellicall,
In their respect unto a man doth fall.

Last, when the sicke or sore are heal'd againe,
And that the Surgeon seekes reward for's paine:
Hee's neither counted God, nor Angel than,
Nor is he intertained as a man.
But (through ingratitude) that hellish evill,
They bid the Surgeon, welcome as the Devill.

From "The Historian's Notebook," *Ohio State Medical Journal,* July, 1943.

Early detection of tuberculosis is not enough. There must be adequate institutional accommodation for those who need it; reasonable maintenance for the family whose wage-earner is undergoing treatment and a wisely planned scheme of rehabilitation are recognized as an essential part of treatment itself.—Sir Wilson Jameson, *Lancet,* October 24, 1942.

The Enchanted Ring . . .

Greatly prized among the Moors is a stone called **ain l-horr.** *It is said that as long as a man wears this gem in a ring of gold he will beget no offspring.**

- An important phase of medical practice and public health programs today is instruction on child-spacing. When the physician advises deferment of pregnancy, modern methods enable him to make his counsel practicable. Ortho-Gynol Vaginal Jelly meets the most exacting requirements for a contraceptive preparation. It immobilizes sperm instantly on contact, is well tolerated in continued use, stable and uniform in its properties. Ortho-Gynol Vaginal Jelly is widely prescribed in doctors' offices and clinics . . . a tribute not only to its effectiveness but to its acceptability among patients.

*Himes, *Medical History of Contraception*

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